

REPORTS OF THE BOARD OF TRUSTEES

The following reports were presented by Bobby Mukkamala, 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, 2021 and 2020 and the Independent Auditor's report have been included in a separate booklet, titled "2021 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. NEW SPECIALTY ORGANIZATIONS REPRESENTATION IN THE HOUSE OF DELEGATES

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) and the Specialty and Service Society (SSS) considered the applications of the American Contact Dermatitis Society, American Society of Regional Anesthesia and Pain Medicine, American Hernia Society, and the Outpatient Endovascular and Interventional Society for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

The applications were considered using criteria developed by the Council on Long Range Planning and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)

Organizations seeking admission were asked to provide appropriate membership information to the AMA. That information was analyzed to determine AMA membership, as required under criterion 3. A summary of this information is attached to this report as Exhibit B.

In addition, organizations must submit a letter of application in a designated format. This format lists the above-mentioned guidelines followed by each organization's explanation of how it meets each of the criteria.

Before a society is eligible for admission to the HOD, it must participate in the SSS for three years. These four organizations have actively participated in the SSS for more than three years.

Review of the materials and discussion during the SSS meeting at the 2021 June and November Special Meetings indicated that the American Contact Dermatitis Society, American Society of Regional Anesthesia and Pain Medicine, American Hernia Society, and the Outpatient Endovascular and Interventional Society meet the criteria for representation in the HOD.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the American Contact Dermatitis Society, American Society of Regional Anesthesia and Pain Medicine, American Hernia Society, and the Outpatient Endovascular and Interventional Society be granted representation in the AMA House of Delegates and that the remainder of the report be filed.

APPENDIX

Exhibit A - GUIDELINES FOR REPRESENTATION IN & ADMISSION TO THE HOUSE OF DELEGATES:

National Medical Specialty Societies

- 1) The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.
- 2) The organization must (a) represent a field of medicine that has recognized scientific validity; and (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:
 - 1,000 or more AMA members;
 - At least 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - Have been 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 5 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 applicable dues are eligible to participate on committees and the governing body.
- 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.

RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS

1. To cooperate with the AMA in increasing its AMA membership.
2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.
3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.
4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting.
5. To provide information and data to the AMA when requested.

Exhibit B - SUMMARY MEMBERSHIP INFORMATION

Organization	AMA Membership of Organization's Total Eligible Membership
American Contact Dermatitis Society	313 of 930 (34%)
American Society of Regional Anesthesia and Pain Medicine	955 of 3,603 (27%)
American Hernia Society	217 of 1,006 (22%)
Outpatient Endovascular and Interventional Society	101 of 250 (40%)

3. 2021 GRANTS AND DONATIONS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

This informational financial report details all grants or donations received by the American Medical Association during 2021.

American Medical Association Grants & Donations Received by the AMA For the Year Ended December 31, 2021 Amounts in thousands		
Funding Institution	Project	Amount Received
Agency for Healthcare Research and Quality (subcontracted through RAND Corporation)	Health Insurance Expansion and Physician Distribution	\$ 25
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	227
Centers for Disease Control and Prevention (subcontracted through American College of Preventive Medicine)	Improving Minority Physician Capacity to Address COVID-19 Disparities	104
Centers for Disease Control and Prevention (subcontracted through National Association of Community Health Centers, Inc.)	Preventing Heart Attacks and Strokes in Primary Care	304
Centers for Disease Control and Prevention	Engaging Physicians to Strengthen the Public Health System and Improve the Nation's Public Health	100
Centers for Disease Control and Prevention	National Healthcare Workforce Infection Prevention and Control Training Initiative Healthcare Facilities	1,000
Centers for Disease Control and Prevention	Promoting HIV, Viral Hepatitis, STDs, and LTBI Screening in Hospitals, Health Systems, and Other Healthcare Settings	187
Health Resources and Services Administration (subcontracted through American Heart Association)	National Hypertension Control Initiative: Addressing Disparities Among Racial and Ethnic Minority Populations	38
Substance Abuse and Mental Health Services Administration (subcontracted through American Academy of Addiction Psychiatry)	Providers Clinical Support System Medicated Assisted Treatment	<u>23</u>
Government Funding		2,008
American Chemical Society	International Congress On Peer Review and Scientific Publication	20
American Heart Association, Inc.	Target: Blood Pressure Initiative	132
The Physicians Foundation, Inc.	American Conference on Physician Health	20
The Physicians Foundation, Inc.	Practice Transformation Initiative: Solutions to Increase Joy in Medicine	40
Nonprofit Contributors		<u>212</u>
Total Grants and Donations		\$ 2,220

4. AMA 2023 DUES

Reference committee hearing: see report of Reference Committee F.

**HOD 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

2023 Membership Year

The Board of Trustees recommends no change to the dues levels for 2023, 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

5. 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, 2021. 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 2021 RESULTS

In 2021, 95 new activities were considered and approved through the Corporate Review process. Of the 95 projects recommended for approval, 52 were conferences or events, 13 were educational content or grants, 22 were

collaborations or affiliations, six were member programs, one was an AMA Innovations, Inc. program, and one was an American Medical Association Foundation (AMAF) program. See Appendix B for details.

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 in cases where 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 2021

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
CONFERENCES/EVENTS			
11126	2021 Erie Neighborhood House Virtual Dinner – Sponsorship with AMA name and logo.	Erie Neighborhood House Cigna John Burns Construction Company ComEd (Commonwealth Edison) Allstate Insurance Company Madigan Family Foundation Teamsters Local 708 VistaNational Insurance Group, Inc. Transportation and Logistics Advisors, LLC	1/13/2021
11137	Minority Health Institute (MHI) Virtual Town Hall – Sponsorship with AMA name and logo.	Minority Health Institute (MHI), Inc. UCLA (University of California Los Angeles) BRITE Center for Science	1/13/2021
15150	AAPC HEALTHCON 2021 – Repeat sponsorship with AMA name and logo.	AAPC (American Academy of Professional Coders) Health Conference	2/9/2021
15157	March of Dimes Gala – Sponsorship with AMA name and logo.	March of Dimes Samsung Electronics Co., Ltd NACDS (National Association of Chain Drug Stores) Foundation Chevron Corporation Comcast NBC (National Broadcast Company) Universal Southern Company Abbott Laboratories Aflac, Inc. Blue Cross Blue Shield Association GM (General Motors Company) National Restaurant Association Volkswagen BGR (Barbour, Griffith & Rogers) Group	2/24/2021
15190	Black Men in White Coats – Sponsorship of documentary screening with AMA name and logo.	Black Men in White Coats United States Navy United States Army Doximity Foundation American Association of Colleges of Osteopathic Medicine DoctorDale Agency LLC DiverseMedicine Inc.	2/8/2021
15245	Becker's Webinar – Sponsorship and co-branding with AMA name and logo.	Becker's Hospital Review	3/2/2021
15299	American Health Information Management Association (AHIMA) Middle East 2021 – Sponsorship of virtual event with AMA name and logo.	American Health Information Management Association (AHIMA) SNOMED International Shearwater Health 3M (formerly Minnesota Mining and Manufacturing Company) Health AccuMed	2/16/2021

15394	Life Sciences Intelligence (LSI) Emerging Medtech Summit 2021 – Sponsorship of virtual event with AMA name and logo.	Life Sciences Intelligence, Inc. (LSI) BioQuest Alira Health Access Strategy Partners, Inc. Triple Ring Technologies PRIA Healthcare Miraki Innovation	3/5/2021
15419	Women Business Leaders Foundation (WBL) Annual Summit 2021 – Repeat sponsorship with AMA name and logo.	Women Business Leaders Foundation (WBL) Amgen, Inc. Anthem, Inc. McKesson Corporation Tivity Health, Inc. Epstein Becker Green, PC Medecision	2/26/2021
15638	National Association of Black Journalists Convention (2021) – Repeat sponsorship with AMA name and logo.	National Association of Black Journalists (NABJ) American Heart Association AARP (American Association of Retired Persons) The Commonwealth Fund Barstool Sports ETS (Educational Testing Service) / GRE (Graduate Record Examinations) Gannett Co., Inc. Amazon Prime Video/"The Boys" series (Amazon.com, Inc.) Spotify Walt Disney World Warner Brothers Entertainment Inc. Wells Fargo	3/19/2021
15787	Digital Health Canada Webinar 2021 – Participation with AMA name and logo.	Digital Health Canada	4/20/2021
15819	Reckoning with Organized Medicine's History of Racism Webinar – Sponsorship with AMA name and logo.	Robert Wood Johnson Foundation W.K. (Will Keith) Kellogg Foundation	4/14/2021
15822	IAIABC Forum 2021 – Sponsorship of virtual event with AMA name and logo.	International Association of Industrial Accident Boards and Commissions (IAIABC) Insurance Services Office, Inc. (ISO) National Council on Compensation Insurance (NCCI) The Black Car Fund Safety National	4/12/2021
15873	UCSF Digital Health Equity Summit – Sponsorship of virtual event with AMA name and logo.	UCSF (University of California, San Francisco) Digital Health Equity Summit Center for Care Innovations Health Tech 4 Medicaid Health Equity Ventures Social Innovation Ventures Health Net, LLC United States of Care	4/15/2021
15902	TSMSS 44th Educational Conference and Exhibition – Sponsorship of virtual event with AMA name and logo.	Texas Society for Medical Services Specialists (TSMSS) IntelliCentrics MD-Staff PreCheck	4/27/2021
15983	CAMSS 50th Annual Educational Forum – Sponsorship of virtual event with AMA name and logo.	CAMSS (California Association of Medical Staff Services)	5/7/2021

15998	CPT/Arab Health 2021 Online Showcase – Sponsorship of virtual event with AMA name and logo.	Arab Health Informa PLC Drager Turkish Healthcare B. Braun Medical Inc. Malaysia Rubber Council (MRC) Shinva Medical Instrument Co., LTD Purell GOJO Industries, Inc.	5/19/2021
16058	Rush University Medical Center - 2021 Virtual Westside Walk for Wellness Initiative – Sponsorship with AMA name and logo.	Rush University Medical Center	5/13/2021
16065	Genetic Health Information Network Summit (GHINS) 2021 – Repeat sponsorship with AMA name and logo.	Concert Genetics, Inc. Genome Medical, Inc. Genetic Health Information Network Summit	6/15/2021
16113	ATA Annual Conference 2021 – Repeat sponsorship of virtual event with AMA name and logo.	ATA (American Telemedicine Association) Amwell (American Well) Zoom Video Communications, Inc. Deloitte eVisit Ziegler (B.C. Ziegler and Company) Teledoc Health, Inc. TytoCare Cisco VMware, Inc. Doximity	5/21/2021
16278	AMA Research Challenge 2021 – AMA branded virtual event with Laurel Road sponsored prize.	Laurel Road	6/21/2021
16321	Society for Human Resource Management Conference – Event exhibit with AMA name and logo.	Society for Human Resource Management (SHRM)	6/14/2021
16353	National Lesbian and Gay Journalists Association (NLGJA) Conference – Repeat sponsorship of virtual event with AMA name and logo.	AARP (American Association of Retired Persons) The Points Guy, LLC WarnerMedia News & Sports The Coca-Cola Company JetBlue Airways Prudential Financial Inc. Knight Foundation (John S. and James L.) Meredith Corporation Craig Newmark Philanthropies PhRMA (Pharmaceutical Research and Manufacturers of America) FOX Walton Family Foundation Pulitzer Center Google News Lab SAG-AFTRA (Screen Actors Guild – American Federation of Television and Radio Artists) TEGNA, Inc. McClatchy Amida Care	6/22/2021
16354	Exhibit at Becker's Hospital Review 12th Annual CEO & CFO Roundtable – Event exhibit with AMA name and logo.	Becker's Healthcare Becker's Hospital Review	7/28/2021

16355	Becker's Hospital Review 12th Annual CEO & CFO Roundtable – Sponsorship of virtual event with AMA name and logo.	Becker's Healthcare Becker's Hospital Review	7/28/2021
16401	73 rd Annual SAWCA Conference (2021) – Sponsorship with AMA name and logo.	Southern Association of Workers' Compensation Administrators (SAWCA) ISO (Insurance Services Office)/Verisk Analytics, Inc. NCCI (National Council on Compensation Insurance) Holdings, Inc. Safety National Trean Corporation Sedgwick UBS Bank (Union Bank of Switzerland) Optum, Inc. ODG an MCG Health Company Akeria Claims Solutions Brentwood Services, Inc. Rehabilitation Advisors Concentra, Inc.	6/28/2021
16575	HIMSS 2021 "Lunch & Learn" Conference – Repeat sponsorship with AMA name and logo.	HIMSS (Healthcare Information and Management Systems Society)	7/16/2021
16579	SNOMED Virtual Clinical Terms (CT) Expo 2021 – Repeat sponsorship of virtual event with AMA name and logo.	Systematized Nomenclature of Medicine (SNOMED) International SNOMED Clinical Terms (CT)	7/21/2021
16621	Becker's 2021 Virtual Executive Roundtable – Sponsorship of hybrid event with AMA name and logo.	Becker's Healthcare Change Healthcare Olive Cerner Grant Thornton LLP Altair Engineering, Inc. Caregility	7/29/2021
16795	Reckoning with Racism Project – Social Determinants of Health Symposium – Sponsorship of event with AMA name and logo.	Modern Healthcare W.K. (Will Keith) Kellogg Foundation Robert Wood Johnson Foundation American Academy of Pediatrics American Psychiatric Association (APA) Becker's Hospital Review	8/12/2021
16825	Modern Healthcare's Virtual Briefing – Sponsorship with AMA name and logo.	Modern Healthcare Podium Corp Inc. Ontrak, Inc. PwC (PricewaterhouseCoopers) Abbott Bristol Myers Squibb VirtualMed Staff LetsGetChecked	8/17/2021
16828	Telehealth Awareness Week Immersion Program – Hosting of virtual bootcamp with AMA name and logo.	American Telemedicine Association (ATA)	8/16/2021
16836	Military Veterans in Journalism (MVJ) Convention – Sponsorship of virtual event with AMA name and logo.	Military Veterans in Journalism Poynter Institute National Association of Hispanic Journalists (NAHJ) The National Press Club CNN (Cable News Network) With Honor DAV (Disabled American Veterans)	8/27/2021

		Wyncote The Washington Post Verizon Media Knight Knight Stanford Fox News Facebook FourBlock Scripps	
16839	Midwest LGBTQ Health Symposium – Repeat sponsorship of virtual event with AMA name and logo.	Howard Brown Health	8/20/2021
16860	Stanford Byers Center for Biodesign Webinar – Sponsorship of virtual CPT event with AMA name and logo.	Stanford Byers Center for Biodesign Fogarty Innovation Wilson Sonsini Goodrich & Rosati Medical Device Manufacturers Association (MDMA) Silicon Valley Bank	8/25/2021
16861	AHIMA 2021 Conference – Repeat sponsorship of virtual event with AMA name and logo.	American Health Information Management Association (AHIMA) 3M (formerly Minnesota Mining and Manufacturing Company) Ciox Iodine	8/26/2021
16983	Current Procedural Terminology (CPT) and Resource-Based Relative Value Scale (RBRVS) 2022 Annual Symposium – Vendors and virtual exhibitors acknowledgement.	The Second City, Inc. The DJ Firm Grubhub AAPC (American Academy of Professional Coders) AHCAE (Association of Health Care Auditors and Educators) AHIMA (American Health Information Management Association) Find-a-Code Haugen Consulting Group Optum, Inc. Association of Health Care Auditors and Educators (AHCAE) American Health Information Management Association (AHIMA)	9/14/2021
17037	AdvaMed MedTech Conference Sponsorship – Sponsorship of hybrid event with AMA name and logo.	AdvaMed Abbott BD (Becton, Dickinson and Company) IQVIA Johnson & Johnson Services, Inc. Medtronic	9/15/2021
17068	NAMSS 45 th Annual Educational Virtual Conference and Exhibition (2021) – Repeat sponsorship with AMA name and logo.	NAMSS (National Association Medical Staff Services) VerityStream PreCheck MD-Staff Symplr AOA Profiles Acorn Credentialing	9/17/2021
17080	Securing Health in a Troubled Time: A National Conversation on Health Inequities - Forum – Sponsorship with AMA name and logo.	The Hastings Center Association of American Medical Colleges United States Department of Veterans Affairs	9/27/2021

17095	Pride South Side Festival 2021 – Sponsorship with AMA name and logo.	Pride South Side (PSS) Public Health Institute of Metropolitan Chicago (PHIMC) Howard Brown Health Blue Cross Blue Shield The Chicago Community Trust Chicago Department of Public Health Molson Coors Beverage Company Comcast Diageo Walgreens Co. Sidetrack Chicago (Side By Side, Inc.) AIDS Foundation Chicago (AFC) Equality Illinois The DuSable Museum of African American History, Inc.	9/23/2021
17101	Health Equity “Basecamp” Leadership Program – Co-branding workshop with AMA name and logo.	Groundwater Institute (GWI) Racial Equity Institute (REI) Impactive Consulting American Diabetes Association (ADA)	9/21/2021
17172	2021 National Addiction Treatment Week (NATW) Campaign – Repeat sponsorship with AMA name and logo.	American Society for Addiction Medicine Association of American Medical Colleges (AAMC) American College of Academic Addiction Medicine American Osteopathic Academy of Addiction Medicine American Society of Addiction Medicine (ASAM) Michigan Cares National Institute on Drug Abuse MED National Institute on Alcohol Abuse and Alcoholism University of California San Francisco (UCSF) Smoking Cessation Leadership Center	9/29/2021
17176	AMA/AHIMA Outpatient Clinical Documentation Improvement Workshop – Repeat virtual event with AMA name and logo.	AHIMA (American Health Information Management Association)	9/28/2021
17186	NAHDO Annual Conference – Sponsorship of hybrid event with AMA name and logo.	National Association of Health Data Organizations (NAHDO) California Health Care Foundation Milliman MedInsight BerryDunn (Berry, Dunn, McNeil & Parker, LLC) Comagine Health Peterson Center on Healthcare HCup (Healthcare Cost and Utilization Project) Mathematica Mercer NORC at University of Chicago Symphony Care, LLC	9/30/2021
17246	AMA Support for National Physician Suicide Awareness Day – Sponsorship with AMA name and logo.	American Academy of Physical Medicine and Rehabilitation Accreditation Council for Graduate Medical Education Ada County Medical Society Akerman Med Alaska State Medical Association American Society of Suicidology	10/5/2021

American Medical Women's Association
 Association of Academy Physiatriests
 Creative Artists Agency
 California Academy of Family Physicians
 California Medical Association
 Carolina Urology Partners
 Connecticut State Medical Society
 Dr. Lorna Breen Heroes' Foundation
 Federation of State Physician Health Programs
 First Responders First
 Florida Medical Association
 Nebraska Medical Association
 Louisiana State Medical Society
 Medical Association of Georgia
 Chattanooga-Hamilton County Medical Society
 Medical Society of the District of Columbia
 Medical Society of New Jersey
 The Medical Society of Northern Virginia
 Medical Society of the State of New York
 Medical Society of Virginia
 The Memphis Medical Society
 Minnesota Medical Association
 MN Mental Health Advocates
 Montgomery County Medical Society
 National Capital Physicians Foundation
 Nebraska Health Network
 New Mexico Medical Society
 North Carolina Osteopathic Medical Association
 North Carolina Medical Society
 North Carolina Society of Osteopathic Family
 Physicians
 North Carolina Rheumatology Association
 Northwell Health
 NYC (New York City) Health + Hospitals
 PBI (Professional Boundaries, Inc.) Education
 South Carolina Medical Association
 Society for Academic Emergency Medicine
 Strelcheck Healthcare Search
 Tennessee Medical Association
 Texas Medical Association
 Thalia's Medicine
 Thrive Global
 Vermont Medical Society
 Volunteers of America
 Washington State Medical Association
 Western Carolina Medical Society

17349	Lakeview Pantry Fighting Hunger, Feeding Hope Event – Sponsorship with AMA name and logo.	Lakeview Pantry IMC (International Marketmaker's Combination) Kovitz Grubhub Huntington Bank Feinberg Foundation Purposeful Wealth Advisors Wintrust (Wintrust Financial Corp.) Kirkland & Ellis LLP CBRE CUBS/Cubs Charities CIBC (Canadian Imperial Bank of Commerce) TDS (Telephone and Data Systems) Advocate/IMMC (Illinois Masonic Medical Center) Asutra	10/7/2021
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17469	2021 Gulf Cooperation Council (GCC) eHealth Workforce Development Conference – Sponsorship with AMA name and logo.	3M (formerly Minnesota Mining and Manufacturing Company) Think Research Elsevier Philips Healthcare InterSystems Orion Health HIMSS (Healthcare Information and Management Systems Society)	10/19/2021
17522	Latino Policy Forum 2021 Virtual Luncheon – Sponsorship with AMA name and logo.	Latino Policy Forums Virtual Policy Illinois Unidos Healthy Communities Foundation Walgreens Co. ADM (Archer Daniels Midland) PNC Bank (Pittsburgh National Corporation/Provident National Corporation) Edwardson Family Foundation Allstate Insurance Company ComEd (Commonwealth Edison) JP Morgan Chase BMO Harris BCBS IL (Blue Cross and Blue Shield of Illinois) Erie Health Centers Peoples Gas FHL Bank (Federal Home Loan) Steams Family Foundation Pierce Family Foundation Rush University Medical Center ABC (American Broadcasting Company) State Farm Mutual Automobile Insurance Company Irving Harris	10/25/2021
17613	Release the Pressure (RTP) with GirlTrek – Collaboration for virtual event with AMA name and logo.	GirlTrek	11/3/2021
17856	2022 International Conference on Physician Health (ICPH) – Sponsorship with AMA name and logo.	British Medical Association Canadian Medical Association	11/22/2021
18209	MedTech Color Collaborative – Sponsorship with AMA name and logo for coalition addressing minority health issues and medical device research and development.	MedTech Color California Health Care Foundation Olympus Health+Commerce Ximeda ResMed Johnson & Johnson Services, Inc.	12/15/2021

EDUCATIONAL CONTENT OR GRANTS

4799	Centering Equity in Emergency Response – A Guide for Healthcare Professionals and Organizations – Updated organizations for co-branded content.	Planned Parenthood Federation of America (PPFA) American College of Preventive Medicine America's Essential Hospitals American Association of Public Health Physicians American Public Health Association National Birth Equity Collaborative East Boston Neighborhood Health Center	3/19/2021
11095	Health System Science (HSS) Podcast Series – Acknowledgement with AMA name and logo.	InsideTheBoards, LLC Ars Longa Media (The Ars Longa Group, LLC)	1/15/2021

11124	Collaboration with HealthBegins, LLC – Hosting of health equity educational activities on AMA Ed Hub.	HealthBegins, LLC Blue Shield of California	5/21/2021
13174	AMA Return on Health Research – Co-branded white papers on telehealth adoption.	Manatt Health (Manatt, Phelps & Phillips, LLP)	1/26/2021
15247	Becker's Whitepaper – AMA co-branding and sponsorship of Joy in Medicine whitepaper.	Becker's Healthcare Review	3/2/2021
15662	COVID Black Educational Modules – Co-branding with AMA name and logo.	COVID Black, LLC	4/1/2021
15686	Edge-U-Cate 2021 Credentialing School Program – Repeat sponsorship with AMA name and logo.	Edge-U-Cate, LLC ABMS Solutions/Certi-FACTS American Osteopathic Information Association (AOIA)	3/30/2021
16176	AMA / AAMC Guide to Language, Narrative, and Concepts – Co-branding of "Guide to Language, Narrative, and Concepts"	Association of American Medical Colleges (AAMC)	6/3/2021
16457	THE CONTAGION NEXT TIME by Sandro Galea – Book quote from Dr. Aletha Maybank.	The Contagion Next Time (Book)	7/7/2021
16489	Alliance for Continuing Education in the Health Professions – Participation in council with AMA name and logo.	Alliance for Continuing Education in the Health Professions Continuing Education for Health Professionals (CEHp) Partners' Council	7/8/2021
16532	ASAM Opioid Use Disorder Educational Activity – Sponsorship with AMA name and logo.	American Society Addiction Medicine (ASAM) Shatterproof	7/9/2021
17036	AMA/CAQH Provider Directory White Paper – Co-branded white paper with AMA name and logo.	CAQH (Council for Affordable Quality Healthcare)	9/15/2021
17792	Health Begins/Patient Social Risk, Equity, & Coding – Co-branded 2021 E/M Coding Guidelines Ed Hub module.	Health Begins, LLC	11/29/2021

COLLABORATIONS/AFFILIATIONS

15152	"Principles for the Use of Funds from the Opioid Litigation" Policy Report – Support and AMA name and logo use with Federation members, universities, and nonprofits.	Johns Hopkins Bloomberg School of Public Health American College of Academic Addiction Medicine American Society of Addiction Medicine American College of Emergency Physicians American Academy of Addiction Psychiatry International Society of Addiction Medicine Shatterproof Partnership to End Addiction Community Anti-Drug Coalitions of America Legal Action Center (LAC) Harm Reduction Coalition National Council for Behavioral Health Margolis Center for Health Policy--Duke University Doris Duke Charitable Foundation Columbia University Department of Epidemiology	2/8/2021
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		Columbia PHIOS (Policy and Health Initiatives on Opioids and Other Substances) Interdisciplinary Initiative Grayken Center for Addiction Medicine, Boston Medical Center Yale Department of Addiction Medicine Boston University School of Public Health University of Southern California Institute of Addiction Sciences	
15170	Human Rights Campaign's Project THRIVE – Collaboration for national LGBTQ equity campaign with AMA name and logo.	Human Rights Campaign (HRC)	6/1/2021
15212	Chicago Area Public Affairs Group 2021 – Repeat sponsorship with AMA name and logo.	Chicago Area Public Affairs Group (CAPAG) Conlon and Dunn Public Affairs Cozen O'Connor Public Strategies Electrical Contractors' Association Fooda, Inc. Strategia	2/3/2021
15473	HL7 Benefactor 2021 – Repeat membership in global healthcare standards organization with AMA name and logo use.	HL7 (Health Level Seven International)	3/3/2021
15691	All In: Well-Being First For Healthcare Campaign – Collaboration with professional well-being program with AMA name and logo.	American Hospital Association American Nurses Association Association of American Medical Colleges Schwartz Center for Compassionate Health Care Dr. Lorna Breen Heroes Foundation Thrive Global Foundation CAA (Creative Artists Agency) Foundation	4/6/2021
15732	Made to Save Public Education Campaign – Collaboration to promote COVID-19 vaccination with AMA name and logo.	Made to Save (Civic Nation)	4/1/2021
15856	Improving Health Outcomes (IHO) Self-Measured Blood Pressure Pilot – Collaboration to increase adoption of patient blood pressure self-monitoring with AMA name and logo.	Ascension Columbia St Mary's Hospital	5/5/2021
15863	Improving Health Outcomes (IHO) Collaboration with Health Care Organizations (HCOs) (2021) – AMA name and logo use alongside these HCOs for hypertension prevention strategies and quality improvement programs.	Mercy Northwest Arkansas, AR University of Colorado Health (Poudre Valley), CO UTMB (University of Texas Medical Branch) Health UT (University of Texas) Physicians Henry Ford Macomb, MI Wilson Value Drug, NC Young Men's Christian Association of Greater St. Petersburg Inc, FL Tampa Metropolitan Area Young Men's Christian Association, Inc., FL Young Men's Christian Association of the Suncoast; Inc., FL YMCA (Young Men's Christian Association) of Delaware, DE Whatley Health Services, Inc., AL Medical University Hospital Authority, SC Long Island Community Hospital, NY	4/22/2021

		Novant Health, NC Mission Health, NC Atrium - The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health, Charlotte, NC Wake Forest Baptist, NC Prisma Health	
16055	Release the Pressure (RTP) Collaboration – To support heart health and self-monitoring blood pressure (SMBP) in a virtual event with AMA.	Alpha Kappa Alpha Sorority	5/11/2021
16095	Collaboration with AHA Foundation – Hosting of health equity educational activities with AMA name and logo.	AHA (Ayaan Hirsi Ali) Foundation	5/25/2021
16831	Joy in Medicine Program – Organization achievement recognition of health care organizations (HCOs) with AMA name and logo.	Atrium Health Atrius Health Bassett Healthcare Network Bayhealth Medical Center BJC Medical Group Bozeman Health Centra Medical Group Children's Mercy Kansas City Children's Primary Care Medical Group ChristianaCare Christus Physician Group Confluence Health Kootenai Health LCMC (Louisiana Children's Medical Center) Health Massachusetts General Physicians Organization MedStar Health Mercy Medical Group Michigan Medicine, University of Michigan MidMichigan Health New Hanover Regional Medical Center Orlando Health Roswell Park Comprehensive Cancer Center Sanford Health South Georgia Medical Center Spectrum Health (Portland, ME) Spectrum Health (Rockford, MI) SUNY Upstate Medical University Thundermist Health Center UCHealth Southern Region UCHealth University of Colorado Hospital on the Anschutz Medical Campus University of Utah Health	8/20/2021
16916	Telehealth Academy Program – Sponsorship with AMA name and logo of program for healthcare providers to integrate telehealth and virtual care into their delivery system.	Telehealth Academy The Nashville Entrepreneur Center Project Healthcare Sage Growth Partners The Disruption Lab	9/2/2021
17000	Kids' Chance of America (KCA) – Collaborative co-promotion with AMA Guides to the Evaluation of Permanent Impairment with AMA name and logo.	Kids' Chance of America	9/21/2021
17056	Health Leaders Marketing Campaign – Co-branding and promotion of white paper.	HealthLeaders/HCPPro	9/17/2021

17200	MAP (Measure, Act, Partner) Dashboards for Health Care Organizations (HCOs) – 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.	Spectrum Health Lakeland USA Health Better Health Partnership Cedars-Sinai Health System ACCESS Community Health Lexington Health, Inc. Lexington Medical Center Network Rush University Medical Center Medical University Hospital Authority (MUHA) Carolina Family Care, Inc. University Medical Associates of the Medical University of South Carolina Carolina Primary Care Physicians, LLC Medical University of South Carolina (MUSC) Beth Israel Deaconess Medical Center, MA Harvard Medical Faculty Physicians, MA Emory University Hospital, GA	10/1/2021
17603	Group Channel Partners for AMA MAP Program – Collaboration with AMA name and logo.	Kansas Primary Care Association - Community Care Network of Kansas Azara Healthcare i2i Population Health Michigan Primary Care Association (MPCA) Health Catalyst, Inc. Wisconsin Primary Health Care Association	11/16/2021
17772	Telehealth Initiative Joint Communications Agreement – Collaboration to support telehealth expansion in practices / health systems with AMA name and logo.	Physicians Foundation Iowa Medical Society (IMS) Montana Medical Society (MMS) Medical Society of the State of New York (MSSNY) Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Massachusetts Medical Society (MMS) Texas Medical Association (TMA) Florida Medical Association (FMA)	11/19/2021
17958	Principles for Equitable Health Innovation Initiative – AMA name and logo association with collaborators supporting innovative health solutions for marginalized communities.	RockHealth.org i.c.stars (Inner-City Computer Stars Foundation) UCSF (University of California San Francisco) SOLVE Health Tech American Hospital Association HealthTech4Medicaid AdvaMed MedTech Color Telehealth Equity Coalition National Health IT Collaborative for the Underserved Center for Care Innovations Consumer Technology Association American Telehealth Association HLTH, LLC MassChallenge Health Tech MATTER West Coast Consortium for Technology & Innovation in Pediatrics HIMSS (Healthcare Information and Management Systems Society) Node.Health Digital Medicine Society Digital Therapeutics Alliance	12/9/2021

		America's Health Insurance Plans Blue Cross Blue Shield Association Business Group on Health	
18005	AMA Physician Innovation Network (PIN) Collaborators – AMA Physician Innovation Network (PIN) collaboration agreements with limited AMA name and logo use.	Nursing Innovation Hub, Inc. (NIHUB) Radical Health	12/3/2021
18125	Equity Campaign – Collaboration announcement with AMA name.	Institute for Healthcare Improvement (IHI) American Hospital Association (AHA) Race Forward	12/3/2021
18231	Current Procedural Terminology (CPT) Webinar – Promotion of educational webinar with AMA name and logo.	Reichman University - Israel Anthem Innovation Israel, Ltd. 8400 – The Health Network Arkin Holdings	12/17/2021
	Glory Skincare – Release the Pressure (RTP) Campaign – Heart health promotion with AMA name.	Glory Skincare	2/2/2021
MEMBER PROGRAMS			
15371	Medline Industries Medical Supplies Affinity Program – Licensing agreement with AMA name and logo.	Medline Industries, LP	3/12/2021
15696	Laurel Road Bank Affinity Program – Addition of two financial products to existing Laurel Road program.	Laurel Road Bank KeyBank (KeyCorp)	4/2/2021
15698	Laurel Road Bank Membership Promotion – AMA membership promotion on Laurel Road Bank customer platform with AMA name and logo.	Laurel Road Bank KeyBank (KeyCorp)	4/8/2021
16697	U.S. Bank National Association Affinity Credit Card Program – Co-branding with AMA name and logo.	U.S. Bank National Association	8/10/2021
16717	Volvo Auto Affinity Program – Licensing agreement with AMA name and logo.	Volvo Car USA, LLC	8/10/2021
	AMA Insurance Agency Supplemental Health Insurance Program with ArmadaCare LLC – Cobranding with AMA Insurance Agency name and logo.	ArmadaCare LLC ArmadaHealth ArmadaGlobal ArmadaCorp Capital Sirius International Insurance Group, Ltd.	2/22/2021
AMA INNOVATIONS INC			
15228	AMA Innovations Inc. License with mmHg, Inc. – License for customized version of mmHg patient facing application to integrate with AMA Innovations Verifi Health technology platform.	mmHg, Inc.	2/2/2021

AMA FOUNDATION

American Medical Association
Foundation (AMAF) Corporate Donors
2021 – Corporate donors for 2021.

Anthem, Inc.
AbbVie, Inc.
Amgen, Inc.
Bristol-Myers Squibb
Eli Lilly
Figs, Inc.
Genentech
GlaxoSmithKline, PLC
Henry Schein
Merck & Co., Inc.
Novartis Pharmaceuticals (Novartis, AG)
Pfizer, Inc.
PhRMA (Pharmaceutical Research and
Manufacturers of America)
Sanofi
Anthem Foundation

12/16/2021

6. 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 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 the 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, including auto 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.

New policy adopted by the AMA HOD during the November 2021 Special Meeting seeks to assist more than 2 million nonelderly uninsured individuals who fall into the “coverage gap” in states that have not expanded Medicaid—those with incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility. The new AMA policy maintains that coverage should be extended to these individuals

at little or no cost, and further specifies that states that have already expanded Medicaid coverage should receive additional incentives to maintain that status going forward.

AMERICAN RESCUE PLAN OF 2021

On March 11, 2021, President Biden signed into law the American Rescue Plan (ARPA) 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 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 FPL for 2021 and 2022.
- Give an option for states to provide 12-month postpartum coverage under State Medicaid and CHIP.

ARPA represents the largest coverage expansion since the Affordable Care Act. Under the ACA, eligible individuals, and families with incomes between 100 and 400 percent of the FPL (between 133 and 400 percent FPL in Medicaid expansion states) have been provided with refundable and advanceable premium credits that are inversely related to income to purchase coverage on health insurance exchanges. However, consistent with Policy H-165.824, ARPA eliminated ACA's subsidy "cliff" for 2021 and 2022. As a result, individuals and families with incomes above 400 percent FPL (\$51,040 for an individual and \$104,800 for a family of four based on 2020 federal poverty guidelines) are eligible for premium tax credit assistance. Individuals eligible for premium tax credits include individuals who are offered an employer plan that does not have an actuarial value of at least 60 percent or if the employee share of the premium exceeds 9.83 percent of income in 2021.

Consistent with Policy H-165.824, ARPA also increased the generosity of premium tax credits for two years, lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark (second-lowest-cost silver) plan. Premiums of the second-lowest-cost silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of their income. Notably, resulting from the changes, eligible individuals and families with incomes between 100 and 150 percent of the federal poverty level (133 percent and 150 percent FPL in Medicaid expansion states) now qualify for zero-premium silver plans, effective until the end of 2022. In addition, individuals receiving unemployment compensation who qualify for exchange coverage are eligible for a zero-premium silver plan in 2021.

In addition, 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 reduces their deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts.

POSSIBLE LEGISLATIVE EXTENSION OF ARPA PROVISIONS

Within an election year and a challenging political environment, it is uncertain whether the Senate and House of Representatives will pass final legislation this year to allow funding for an extension of the aforementioned ACA subsidies included within the ARPA as well as provisions to close the Medicaid "coverage gap" in the States that have not chosen to expand.

ACA ENROLLMENT

According to the U.S. Department of Health and Human Services (HHS), 14.5 million Americans have signed up for or were automatically re-enrolled in the 2022 individual market health insurance coverage through the Marketplaces since the start of the 2022 Marketplace Open Enrollment Period (OEP) on November 1, 2021, through January 15, 2022. That record-high figure includes nearly 2 million new enrollees, many of whom qualified for reduced premiums granted under ARPA.

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 was expected before June 2021. The AMA filed an amicus brief in support of the Act and the petitioners in this case.

On February 10, 2021, the U.S. 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 pointed 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.

On June 17, 2021, the Supreme Court in a 7-2 decision ruled that neither the states nor the individuals challenging the law have a legal standing to sue. The Court did not touch the larger issue in the case: whether the entirety of the ACA was rendered unconstitutional when Congress eliminated the penalty for failing to obtain health insurance.

With its legal status now affirmed by three Supreme Court decisions, and provisions such as coverage for preventive services and pre-existing conditions woven into the fabric of U.S. health care, the risk of future lawsuits succeeding in overturning the ACA is significantly diminished.

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.

The AMA is now working on unrelated new Medicare payment reduction threats and is currently advocating for a sustainable, inflation-based, automatic positive update system for physicians.

INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

The Bipartisan Budget Act of 2018 signed into law by President Trump on February 9, 2018, included provisions repealing 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.

7. AMA PERFORMANCE, ACTIVITIES, AND STATUS IN 2021

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 extend across all physicians, as well as policymakers, medical schools, and health care leaders, the AMA uniquely can deliver results and initiatives that enable physicians to improve the health of the nation.

Representing physicians with a unified voice

AMA-led grassroots efforts resulted in 250,000 emails and more than 8,000 phone calls to Congress, pushing lawmakers to take urgent action in December to avert devastating Medicare physician payment cuts totaling nearly 10%. AMA actions helped secure temporary sequester relief, a Physician Fee Schedule increase, and a significant Medicare PAYGO cut for 2022.

The AMA lobbied successfully for several government interventions to help with the public health and practice-based issues resulting from the COVID-19 Public Health Emergency. The Administration doubled Medicare payment for administration of the COVID-19 vaccine to \$40 per administration and pressed states to allocate vaccines for administration in physician offices.

The AMA elevated the voice of leadership on critical issues of public health during the pandemic, securing more than 94 billion media impressions representing nearly \$870 million in estimated ad value. AMA's share of voice during COVID-19 continues to lead all other health care organizations.

The AMA worked closely with state medical associations to produce scope of practice legislation that yielded victories in more than 20 states, as well as important concessions to reduce the burden of prior authorization on patients and physicians.

The AMA worked with the Centers for Disease Control and Prevention (CDC) to provide innovative and highly effective infection control training for physicians and other frontline health care workers through Project Firstline.

The AMA successfully promoted use of the Defense Production Act to boost production of personal protective equipment for physicians and vaccines, as well as onshore production rapid COVID-19 tests. AMA advocacy also contributed to expanded testing and increased FDA Emergency Use Authorizations to speed the process and yield better-informed policy decisions.

The AMA responded to the urgent needs of physicians during COVID-19 as the Current Procedural Terminology (CPT®) Panel team worked closely with the CPT Editorial Panel and the CDC to quickly issue 19 new CPT vaccine and vaccine administration codes, along with guidance on their appropriate use.

The AMA was a tireless advocate for physicians in federal and state courts, and our legal arguments and medical expertise were instrumental in dismissing the latest attempts to undermine the Affordable Care Act and laws that would harm transgender youth, as well as informing key decisions on federal vaccine and testing mandates, access to COVID-19 vaccines for young people, protection from eviction during the pandemic, and provider liability for COVID-19-related care.

The AMA's friend of the court brief was cited favorably by the U.S. Supreme Court in its decision rejecting challenges to the CMS vaccine mandate. Additionally, through its role as a plaintiff in two separate lawsuits, the AMA helped achieve favorable government action involving both the regulation of menthol cigarettes and the Title X program, protecting the patient-physician relationship, and defending the freedom of communication between patients and their physicians.

Building support for improved mental health during a time of extreme stress, AMA Insurance partnered with ArmadaCare, a leading insurance program manager, to offer a new supplemental health insurance program for physician groups.

Removing obstacles that interfere with patient care

The AMA created a broad range of research and resources dedicated to professional well-being and physician practice viability, including authoring or co-authoring 21 peer-reviewed articles and a whitepaper that assessed the factors that create and sustain high-performing physician-owned practices. Additionally, more than 40 health systems were singled out during the first full year of the AMA Joy in Medicine™ Health System Recognition Program, which offers a roadmap to boosting physician satisfaction.

The AMA expanded its Behavioral Health Integration initiative to help physician practices better meet patients' mental and physical health needs with 10 new webinars, six podcasts, four practice how-to guides, and an updated BHI

Compendium outlining the initial steps of integrated behavioral care delivery. Additional resources to support private practice physicians included on-demand webinars and a live educational session during the November Special Meeting.

The AMA launched five new resources for private practice physicians in 2021, including a live educational session at the November Special Meeting and three new on-demand webinars. The popular AMA STEPS Forward® online training program expanded with eight new and 17 updated toolkits, more than two dozen webinars, and 14 podcasts.

The AMA contributed to the Robert Wood Johnson Foundation's National Commission to Transform Public Health Data Systems, which promises to modernize data collection to better target interventions and resources.

Leading the charge to confront public health crises

The AMA built on its industry-leading work to stem the rise in chronic disease, particularly among historically marginalized communities, by co-authoring 14 publications on inequities in blood pressure control and providing direct support to patients, physicians, and health care teams nationwide.

The AMA became a leading voice nationally in advancing equity in medicine with the launch of its ambitious multi-year strategic plan to embed equity across the organization and in all of its actions.

A pandemic-inspired shift to virtual coaching helped more health care organizations implement AMA MAP BP™, our evidence-based quality improvement program targeting patients at risk of developing heart disease.

The AMA and West Side United collaborated to improve heart health on Chicago's West Side. AMA co-led efforts to distribute 1,000 validated BP measurement devices and accompanying SMBP training resources to residents.

Our national Release The Pressure initiative, designed to provide Black communities with the knowledge and resources to achieve optimal heart health, provided self-measured blood pressure training to more than 72,000 Black women.

Seeking to harness the power of health data through a common framework, AMA's Integrated Health Model Initiative published a national mandated standard for social determinants of health, positioning the AMA as a leader in this growing and increasingly important field.

Only in its third 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 with the Center for Health Equity's strategic plan to support thriving, healthy, and equitable communities. Thirty-two percent of AMA employees, representing every business unit, supported nearly 100 organizations and donated \$113,000 to community partners.

AMA's ESR program was recognized by Erie Neighborhood House with the Community Investment award. The Community Investment award reflects AMA's commitment to helping communities thrive and giving communities hope.

Driving the future of medicine

AMA's JAMA Network expanded its family of specialty journals with the launch of JAMA Health Forum, a peer-reviewed, open-access online journal that focuses on health policy and health care systems as well as global and public health.

Total sessions across the JAMA Network surpassed the 100-million mark for the second straight year, aided by the Coronavirus Resource Center which has proven to be an essential and trusted source of information for physicians, researchers, and patients.

The AMA created a cross-sector External Equity and Innovation Advisory Group, launched a series of equity-focused educational modules for CME credit on the AMA Ed Hub™ and partnered with the Association of American Medical Colleges to launch a language guide to help physicians better understand the role dominant narratives play in medicine.

The AMA built on its commitment to health equity, working to develop and implement a framework to embed equity across the organization.

The AMA Ed Hub™, an industry-leading online education platform, drew more than 6.4 million views and kept physicians informed on COVID-19, health equity, physician wellness, telemedicine, diabetes prevention, and a host of other topics, while offering CME credits. AMA Ed Hub™'s content now includes research and insights from 24 outside organizations.

With nearly 4 million visits to its website in 2021 and a popular podcast, the *AMA Journal of Ethics*® provided expert ethics guidance to help physicians and medical students navigate complex medical decisions on topics ranging from advancing racial justice and equity in health care to addressing transgenerational trauma and diversity in medical school admissions.

The AMA launched the CPT Capstone series with six sessions to educate the innovator community on the CPT process and AMA's work in innovation and health equity. In addition, AMA launched a well-received series of CPT webinars addressing a broad range of topics attended by more than 20,000 participants.

We launched the AMA Intelligent Platform, a digital platform supporting a new and modern interface to the CPT Code Set and supporting data assets including a CPT API.

The AMA-convened Digital Medicine Payment Advisory Group launched an augmented intelligence taxonomy that provides structure and direction to this evolving area of organized medicine.

Since its launch in May, two dozen Federation partners have joined the AMA Telehealth Immersion Program, and thousands of physicians have improved their understanding and streamlined implementation of telehealth into their practices through the AMA's Telehealth Implementation and Remote Patient Monitoring Implementation playbooks, as well as the Telehealth Quick Guide and Telehealth Educators Playbook.

AMA's years-long effort to reinvent medical school education advanced with six Innovations in Medical Education webinars that engaged medical students in urgent health care topics, including a focus on the impact of structural racism in medicine that drew more than 1,300 participants. Additionally, AMA funded three grants to boost diversity and dismantle systemic racism in medical education as part of The Bright Ideas Showcase at its annual Change MedEd 2021 event.

The AMA published a supplement in *Medical Teacher* with a series of articles describing the work, and lessons from the work, of the consortium to deeply reform medical education by expanding the implementation of competency-based medical education; leveraging the power of information in delivering both care and education; viewing health systems science as a new form of professionalism in medicine; strengthening interdependence among educational programs, communities, and health systems; and aligning the development of the health care workforce with societal needs and enhanced diversity.

The rapid expansion of audio and video programming and other online content drew a record 27.3 million unique users to the AMA website in 2021, a 35% year-over-year increase. The AMA COVID-19 Resource Center recorded nearly twice as many users as the previous year, while podcast downloads and video watch times also rose sharply. Five informational webinars AMA hosted with experts from the FDA and CDC were viewed more than 20,000 times.

Membership

The myriad ways AMA supported physicians in 2021 contributed to another strong financial performance, the 11th consecutive year of membership growth, and the highest number of dues-paying members since 2001.

EVP Compensation

During 2021, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was \$1,223,228 in salary and \$1,171,835 in incentive compensation, reduced by \$4,598 in pre-tax deductions. Other taxable amounts per the contract are as follows: \$23,484 imputed costs for life insurance, \$24,720 imputed costs for executive life insurance, \$3,360 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 2021 Annual Report.”

8. ANNUAL UPDATE ON ACTIVITIES AND PROGRESS IN TOBACCO CONTROL: MARCH 2021 THROUGH FEBRUARY 2022

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 2021 through February 2022. The report is written pursuant to AMA Policy D-490.983, “Annual Tobacco Report.”

TOBACCO USE AND COVID-19

Since March 2020 COVID-19 and the resulting pandemic dominated the public health and health care landscape. The Centers for Disease Control and Prevention (CDC) began publishing an ongoing list of conditions likely to cause or may cause more severe outcomes in adults with COVID-19 based on available evidence. Health care providers could use this list to identify their patients at high risk of poor or fatal outcomes associated with contracting COVID-19. Smoking was included in CDC’s higher risk category for severe COVID-19 outcomes. The CDC’s analysis determined that this was true in former smokers as well. Smoking was not associated with higher risk of contracting COVID-19. According to an observational study in *Nicotine & Tobacco Research*, Impact of Tobacco Smoking on the Risk of COVID-19: A Large Scale Retrospective Cohort Study, smokers could be less susceptible to COVID-19. The authors stressed that this indicates the need for further research and not that smoking is considered a protection against contracting the virus.¹

Uptick in Tobacco Use

The lockdowns associated with the pandemic resulted in an increased prevalence in unhealthy behaviors. These included poor dietary intake, decreased physical activity, and increased smoking.²

The rise in tobacco use was also demonstrated in the Federal Trade Commission’s 2020 cigarette report, which showed an increase in cigarette sales for the first time in 20 years.³ It is expected to see this continued upturn in the 2021 report. While the report does not indicate the pandemic and its subsequent lockdowns as the cause of the upsurge, Bloomberg reported that Altria’s sales jumped because of what the company calls “pantry loading,” which suggests smokers were stocking up on cigarettes. Altria Group is one the largest producers of cigarettes, tobacco, and nicotine products in the world.⁴

Pandemic Impacts Tobacco Cessation

“During the pandemic, smokers might have increased their smoking due to stress and boredom. On the other hand, the fear of catching COVID and risk for poor outcomes from COVID might have led them to cut down or quit smoking. In fact, we found that both happened,” said Nancy Rigotti, MD, Director of Tobacco Research and Treatment Center at Massachusetts General Hospital. Rigotti and colleagues analyzed data on current and former smokers who had been hospitalized before the pandemic and had previously participated in a smoking cessation clinical trial.⁵

Tobacco smoking is the leading cause of preventable death in the United States. The risks associated with poor COVID-19 outcomes for smokers was an opportunity for physicians to elevate conversations about quitting. It was also an opportunity for public health agencies to highlight the available cessation tools including online programs and state supported quit lines.

E-Cigarette Use by Youth Suggests Strong Nicotine Dependence

According to the 2021 National Youth Tobacco Survey (NYTS), more than 2 million middle and high school students use e-cigarettes. An analysis by the U.S. Food and Drug Administration (FDA) and CDC estimate that one in four use e-cigarettes daily.⁶ The data also show a change in teen e-cigarette preferences.

For years, Juul was the most popular brand with its flash drive-like devices and pre-filled nicotine liquid cartridges, but the 2021 NYTS data shows that Puff Bar is the brand of choice. Puff Bar is a disposable e-cigarette in flavors such as Blue Razz and Watermelon.

The 2021 data cannot be compared to previous surveys due to changes made to how the survey was conducted during the pandemic. The NYTS was designed to provide national data on long-term, intermediate, and short-term indicators key to the design, implementation, and evaluation of comprehensive tobacco prevention and control programs.

Bipartisan Legislative Agreement Closes Loophole in FDA Authority

In response to the rising concern about the proliferation of e-cigarettes using synthetic nicotine, Congress introduced legislation to enable FDA to regulate synthetic nicotine products. The bipartisan agreement is included in the omnibus appropriations bill.

Current federal law (the 2009 Family Smoking Prevention and Tobacco Control Act) gives the FDA the authority to regulate tobacco products and defines a “tobacco product” as a product made or derived from tobacco. To evade FDA regulation, a growing number of e-cigarette manufacturers have switched to using synthetic nicotine—nicotine that is made in a lab rather than derived from tobacco—and are marketing these products with the kid-friendly flavors. In 2009 the FDA ordered Puff Bar, a leading e-cigarette manufacturer, to remove its flavored disposable products from the market. In 2021, it reentered the market as a synthetic nicotine e-cigarette.

TOBACCO AND HEALTH EQUITY

AMA Calls on FDA to Prioritize Its Enforcement as Authorized by Congress

In an August 9, 2021, letter to the FDA’s Center for Tobacco Products, the AMA called on the FDA to prioritize enforcement against two manufacturers for introducing new flavored tobacco products in defiance of the FDA review requirements. The AMA was one of 15 co-signers that included the American Academy of Pediatrics, National Medical Association, Black Women’s Health Imperative, The Center on Black Health & Equity, NAACP and others.

According to the NAACP the tobacco industry has successfully and intentionally marketed mentholated cigarettes to African Americans and particularly African American women and menthol smokers have a harder time quitting smoking.⁷

Reynolds American, Inc. introduced Newport Boost menthol cigarettes and Swedish Match introduced a “Limited Editions Chocolate and Vanilla Swirl.” The Family Smoking Prevention and Tobacco Control Act (TCA) does not permit the introduction of new tobacco products (those introduced or modified after February 15, 2007), without rigorous premarket review by FDA and the issuance of premarket orders authorizing their sale. In April 2021, in part because of a lawsuit filed by the AMA and others, FDA announced it would advance two tobacco product standards: prohibiting menthol as a characterizing flavor in cigarettes; and prohibiting all characterizing flavors, including menthol, in cigars. Since then, the FDA has denied applications for 55,000 flavored e-cigarette products.

The letter also called on the FDA to expedite the issuance of proposed and final rules to establish menthol cigarette and flavored cigar product standards to eliminate these products from the marketplace.

OTHER EFFORTS TO ADDRESS TOBACCO CONTROL

USPSTF Expands Criteria for Lung Cancer Screening

The US Preventive Services Task Force has expanded the criteria for lung cancer screening. The updated final recommendations have lowered the age at which screening starts from 55 to 50 years and have reduced the criterion

regarding smoking history from 30 to 20 pack-years. The updated final recommendations were published online on March 2021 in *JAMA*.⁸

According to the evidence review conducted by the Task Force, lung cancer is the second most common cancer and the leading cause of cancer death in the US. Smoking accounts for an estimated 90% of all lung cancer cases. Lung cancer has a generally poor prognosis, with an overall 5-year survival rate of 20.5%. However, early-stage lung cancer has a better prognosis and is more amenable to treatment.

Graphic Warning Labels Impact Perceptions About Smoking

Graphic warning labels on cigarette packages changes positive perceptions and increases awareness according to a study on JAMA Network Open.⁹ Earlier studies have shown evidence of increased quit attempts when smokers have graphic warning labels affixed to the cigarette pack.¹⁰ In 2009, graphic warning labels on cigarette packs were mandated by Congress. Despite attempts by the tobacco industry to delay implementation through lawsuits, the courts confirmed FDA's obligation to create and require graphic warning labels on cigarette packages. The AMA joined with other medical organizations and public health groups in filing amicus briefs in support of the FDA's mandated actions. It is estimated that more than 180,000 deaths could have been prevented over the past decades if graphic warning labels had been in place.¹¹

The use of government imposed graphic labels has been a useful tool in other countries for more than 20 years. Today 120 counties mandate graphic warning labels.

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9. COUNCIL ON LEGISLATION SUNSET REVIEW OF 2012 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 (HOD) adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the HOD to retain it. Any action of our AMA HOD 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 HOD 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; or (f) The Speakers shall determine the best way for the HOD to handle the sunset reports.
3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.
4. The AMA councils and the HOD 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 HOD 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-155.990	Responsibility for Transparency	Our AMA will actively oppose any legislation and/or regulation that deems the physician the responsible party to inform patients of their anticipated health care costs where the practitioner does not set reimbursement rates. (Res. 819, I-12)	Retain – this policy remains relevant.
D-160.999	Opposition to Criminalizing Health Care Decisions	Our AMA will educate physicians regarding the continuing threat posed by the criminalization of healthcare decision-making and the existence of our model legislation “An	Retain – this policy remains relevant.

		<p>Act to Prohibit the Criminalization of Healthcare Decision-Making.”</p> <p>(Res. 228, I-98; Reaffirmed: BOT Rep. 5, A-08; Reaffirmation: I-12)</p>	
D-185.986	Third Party Payer Coverage Process Reform and Advocacy	<p>1. Our AMA, working with interested state medical and national specialty societies, will develop model legislation and/or regulations to require that commercial insurance companies, state Medicaid agencies, or other third-party payers utilize transparent and accountable processes for developing and implementing coverage decisions and policies, and will actively seek the implementation of such model legislation and/or regulations at the national and state levels.</p> <p>2. Our AMA will work with specialty and service organizations to advocate that private insurance plans and benefit management companies develop transparent clinical protocols as well as formal processes to write / revise them; that those processes should seek input from the relevant national physician organizations; and that such clinical coverage protocols should be easily and publicly accessible on their websites, just as Medicare national and local coverage determinations are publicly available.</p> <p>3. Our AMA will advocate that when private insurance plans and benefit management companies make changes to or revise clinical coverage protocols, said companies must inform all insured individuals and participating providers in writing no less than 90 days prior to said change(s) going into effect.</p> <p>(Res. 820, I-11; Appended: Res. 807, I-12)</p>	Retain – this policy remains relevant.
D-190.984	HIPAA	<p>Our AMA continue to identify and work toward the repeal of the onerous provisions in the Health Insurance Portability and Accountability Act legislation and regulations, including its criminal liability provisions, and that our AMA work to redress the breaches of patient confidentiality that the HIPAA regulations have allowed.</p> <p>(Res. 901, I-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)</p>	Retain – this policy remains relevant.
D-190.988	HIPAA interference with Peer Review Activities	<p>Our AMA shall seek immediate clarification from the Department of Health and Human Services of the impact of the Health Insurance Portability and Accountability Act Privacy Rule on the peer review process.</p> <p>(Res. 721, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)</p>	<p>Sunset this policy.</p> <p>HIPAA does not pose issues with the peer review process; presumably when the law first came out, physicians may have thought they would not be able to share protected health information for peer review, but HIPAA’s regulations allow that type of discussion.</p>
D-190.989	HIPAA Law And Regulations	<p>(1) Our AMA shall continue to aggressively pursue modification of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to remove burdensome regulations that could interfere with efficient patient care.</p>	<p>Retain and modify part of this policy.</p> <p>Rescind clause 2 and 3, and renumber and modify clause 4. Clause 2 is outdated and no</p>

		<p>(2) If satisfactory modification to the HIPAA Privacy Rule is not obtained, our AMA shall aggressively pursue appropriate legislative and/or legal relief to prevent implementation of the HIPAA Privacy Rule.</p> <p>(3) Our AMA shall continue to oppose the creation or use of any unique patient identification number, including the Social Security number, as it might permit unfettered access by governmental agencies or other entities to confidential patient information.</p> <p>(4)(2) Our AMA shall immediately begin working <u>continue to work</u> with the appropriate parties and trade groups to explore ways to help offset the costs of implementing the changes required by the Health Insurance Portability and Accountability Act <u>associated with HIPAA compliance</u> so as to reduce the fiscal burden on physicians.</p> <p>(Sub. Res. 207, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)</p>	<p>longer applicable. Regarding clause 3, opposing unique patient identification number policies harms more than helps in certain stakeholder circles. Renumber clause 4 to be clause 2 and modify the clause by updating the language to be more in line with the wording of clause 1.</p>
D-230.991	Inspector General to Rule on Exclusivity Restrictions for Medical Staff Membership	<p>Our AMA will (1) continue its discussions with the Office of Inspector General of Health and Human Services and urge the OIG to issue a fraud alert on the practice of exclusive credentialing; and (2) take other appropriate action, which may include administrative action, litigation, and/or legislation, to protect our patients from being denied quality medical care through exclusive (including economic) credentialing by hospitals.</p> <p>(Res. 714, I-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)</p>	Retain – this policy remains relevant.
D-235.987	Medical Staff Bylaws as Binding Contracts	<p>Our AMA will actively pursue the enactment of federal legislation and/or regulation that will recognize medical staff bylaws as a binding contract, not subject to unilateral amendment, between the organized medical staff and the governing board of a hospital or health care delivery system.</p> <p>(Sub. Res. 818, I-12)</p>	<p>Sunset this policy.</p> <p>This resolution was based on a Minnesota trial court case that held that medical staff bylaws should not be deemed a contract between the medical staff and the hospital. Subsequent to the HOD's adoption of this resolution, in December 2014, the Minnesota Supreme Court overruled the trial court's decision and held that medical staff bylaws could be enforced as a contract. The AMA's Litigation Center supported this case. Medical staff contract issues are primarily regulated at the state level. The AMA's Advocacy Resource Center, through the Council on Legislation, has developed model state legislation entitled an "Act to Ensure the Autonomy of Hospital Medical Staffs." In</p>

			addition, AMA Policy H-235.976 recognizes that medical staff bylaws are a contract between the organized medical staff and the hospital.
D-315.991	Medical Records with Bills	Our AMA shall cause to be introduced legislation that would: (1) establish criteria defining when the request for medical records from a third party payer is appropriate, and (2) require insurance companies to pay for copied medical records requested by said insurance company at the rate established by law. (Res. 218, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)	Retain – this policy remains relevant.
D-330.915	RAC Audits of E&M Codes	1. Our AMA opposes Recovery Audit Contractor audits of E&M codes with the Centers for Medicare & Medicaid Services (CMS) and will explain to CMS and Congress why these audits as currently conducted are deleterious to the provision of care to patients with complex health needs. 2. If our AMA is unsuccessful in reversing the audits, our AMA will urge CMS and elected Washington officials to require physician reimbursement for time and expense of appeals. 3. Our AMA will urge CMS and elected Washington officials to provide statistical data regarding the audits, including the specialties most affected by these audits, and the percentage of denied claims for E&M codes which, when appealed, are reversed on appeal. (Res. 224, I-12)	Retain – this policy remains relevant.
D-330.966	Medicare Program Safeguard Contractors	Our AMA, consistent with the principles set forth in its September 2001 letter to the Centers for Medicare & Medicaid Services, shall continue to press for legislative and/or administrative relief from the creation of Program Safeguard Contractors and other abusive contracting authority by CMS. (Res. 709, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)	Retain – this policy remains relevant.
D-35.987	Evaluation of the Expanding Scope of Pharmacists' Practice	Our AMA: (1) will re-evaluate the expanding scope of practice of pharmacists in America and develop additional policy to address the proposed new services provided by pharmacists that may constitute the practice of Medicine; (2) will continue to collect and disseminate state specific information in collaboration with state medical societies regarding the current scope of practice for pharmacists in each state; studying if and how each state is addressing these expansions of practice; (3) will develop model state legislation to address the expansion of pharmacist scope of practice that is found to be inappropriate or constitutes the practice of medicine, including but not limited to the issue of interpretations or usage of independent practice arrangements without appropriate physician supervision and work with interested states and specialties to advance such	Retain – this policy remains relevant.

		<p>legislation; (4) opposes federal and state legislation allowing pharmacists to independently prescribe or dispense prescription medication without a valid order by, or under the supervision of, a licensed doctor of medicine, osteopathy, dentistry or podiatry; (5) opposes federal and state legislation allowing pharmacists to dispense medication beyond the expiration of the original prescription; and (6) opposes the inclusion of Doctors of Pharmacy (PharmD) among those health professionals designated as a “Physician” by the Centers for Medicare & Medicaid Services.</p> <p>(Res. 219, A-11; Appended: Res. 218, A-12)</p>	
D-383.984	ERISA and Managed Care Oversight	<p>Our AMA will develop, propose, and actively support (1) federal legislation clarifying that ERISA preemption does not apply to physician/insurer contracting issues; (2) federal legislation that requires all third party payers serving as administrators for ERISA plans to accept assignment of benefits by patients to physicians; and (3) federal and state legislation prohibiting “all products” clauses or linking participation in one product to participation in other products (“tied”) administered or offered by third party payers or their affiliates.</p> <p>(Res. 915, I-06; Reaffirmed: Res. 223, I-10; Reaffirmed: CMS Rep. 6, A-12)</p>	<p>Retain – this policy remains relevant.</p> <p>This policy supports changes to the scope of ERISA preemption. ERISA preemption is a barrier to the AMA’s and the Federation’s advocacy in support of protecting physicians through state regulations from the adverse business practices of many of the payers with whom physicians contract.</p>
D-390.986	Medicare Balance Billing	<p>Our American Medical Association: (1) advocate that physicians be allowed to balance bill Medicare recipients to the full amount of their normal charge with the patient responsible for the difference between the Medicare payment and the physician charges; (2) seek introduction of national legislation to bring about implementation of balance billing of Medicare recipients; and (3) further advocate that such federal laws and regulations pre-empt state laws that prohibit balance billing.</p> <p>(Res. 713, I-02; Reaffirmation A-04; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: CMS Rep. 5, I-12)</p>	Retain – this policy remains relevant.
D-478.984	Clinical Data Repositories for Physicians, Patients and Continuous Quality Improvement	<p>Our American Medical Association will (1) collect and make available the best practices resulting from existing pilot Clinical Data Repository (CDR) projects to demonstrate the most appropriate measures and data aggregation methods for assessing physician performance, and to demonstrate how best to use clinical data to improve quality of patient care; and (2) identify and disseminate educational materials to be used by physician organizations and communities on how to best use data from CDRs in practice improvement, quality improvement, and contracting.</p> <p>(BOT Rep. 3, I-09; Reaffirmed in lieu of Res. 704, A-12)</p>	Retain – this policy remains relevant.

D-525.998	Mammography Screening for Breast Cancer	In order to assure timely access to breast cancer screening for all women, our AMA shall advocate for legislation that ensures adequate funding for mammography services. (Res. 120, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)	Retain – this policy remains relevant
D-85.994	Strengthening Medicolegal Death Investigations	Our AMA will work with interested states on legislation to facilitate the transition from coroner systems to medical examiner systems. (Res. 718, A-12)	Retain – this policy remains relevant.
H-100.954	Stimulate Antibiotic Research and Development	Our AMA supports legislation requiring the re-evaluation of FDA guidelines for clinical trials of antibiotics, including an increase in the period of market exclusivity. (Res. 210, A-12)	Sunset this policy. The Generating Antibiotic Incentives Now (GAIN) Act of 2012 was enacted after this resolution was adopted. The law increased exclusivity for antibiotics for 5 years and required FDA to evaluate ways to ensure continued research on antibiotics (which FDA subsequently did in updates to 3 different guidances).
H-100.957	Repeal of the Federal Restriction on the Use of Tax Exempt Funds to Buy Medications Without a Prescription in the PPACA (Health Reform Law)	Our AMA supports the repeal of the federal restriction on the use of tax-exempt funds to buy medications without a prescription and will formally notify the appropriate federal legislative bodies and regulatory agencies of this support for repeal. (Res. 211, A-11; Reaffirmation A-12)	Retain – this policy remains relevant.
H-120.938	Opposition to FDA's Rx to OTC Paradigm Shift	Our AMA will: (1) submit comments during the public comment period expressing our concerns with the Food and Drug Administration's (FDA's) proposed paradigm shift; (2) continue to monitor FDA's action on this issue; (3) encourage the FDA to study the cost implications switching prescription drugs to over-the-counter status will have on patient out of pocket costs; and (4) strongly encourage the FDA to initiate a formal public comment process before reclassifying any prescription drug to over-the-counter status. (Res. 235, A-12)	Retain – this policy remains relevant.
H-160.946	The Criminalization of Health Care Decision Making	The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.	Retain – this policy remains relevant.

		(Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12)	
H-165.841	Comprehensive Health System Reform	<p>Our AMA supports the overall goal of ensuring that every American has access to affordable high quality health care coverage and will work with interested members of Congress to seek legislation consistent with AMA policy.</p> <p>(Sub. Res. 924, I-07; Reaffirmed: Res. 239, A-12)</p>	<p>Sunset this policy.</p> <p>This has been accomplished through the Affordable Care Act and superseded by more recent policy, H-165.838.</p>
H-175.985	Kennedy-Kassebaum: Fraud and Abuse	<p>Our AMA: (1) will work to alleviate the oppressive, burdensome effects on physicians of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); (2) opposes efforts to repeal provisions in Health Insurance Portability and Accountability Act of 1996 (HIPAA) that would alter the standard of proof in criminal and civil fraud cases or that would eliminate the ability of physicians to obtain advisory opinions regarding anti-kickback issues; and thoroughly evaluate and oppose other fraud and abuse proposals that are inappropriately punitive to physicians;</p> <p>(3) will ensure that any proposed criminal fraud and abuse proposals retain the current intent standard of “willfully and knowingly” to be actionable fraud; and that the AMA oppose any effort to lower this evidentiary standard;</p> <p>(4) will vigorously oppose efforts by the Department of Justice to punish and harass physicians for unintentional errors in Medicare claims submissions and the legitimate exercise of professional judgment in determining medically necessary services;</p> <p>(5) continues its efforts to educate the entire Federation about the AMA’s successful amendment of the Health Insurance Portability and Accountability Act (also commonly referred to as the Kassebaum-Kennedy bill) which resulted in language being added so that physicians cannot be prosecuted or fined for inadvertent billing errors, absent an intent to “knowingly and willfully” defraud;</p> <p>(6) educates the public and government officials about the distinction under the law, between inadvertent billing errors and fraud and abuse; and</p> <p>(7) responds vigorously to any public statements that fail to distinguish between inadvertent billing errors and fraud and abuse.</p> <p>(Sub. Res. 222, A-97; Appended: Res. 202, I-98; Reaffirmation A-99; Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, A-12)</p>	Retain – this policy remains relevant.
H-175.989	Health Care Fraud Legislation	<p>Our AMA: (1) should continue to scrutinize current and future key legislation regarding health care fraud and abuse;</p> <p>(2) should use all appropriate resources available to ensure that any proposed sanctions, penalties, or sentences be commensurate with the offense committed,</p>	<p>Sunset this policy.</p> <p>This policy is very specific to a policy trend that was occurring in 1992 that has long been eclipsed by other issues and approaches regarding fraud and abuse issues.</p>

		<p>especially regarding the imposition of criminal penalties in measures that fail even to define the boundaries of a “health care offense” or to establish the requisite intent necessary for conviction;</p> <p>(3) should work with appropriate federal agencies and congressional committees in studying the extent to which health care fraud pervades the current environment;</p> <p>(4) should continue to support legislative measures such as HR 5120, which would establish a national commission to investigate the nature, magnitude, and cost of health care fraud and abuse;</p> <p>(5) should conduct surveys and research in order to develop data on possible abuses in the system;</p> <p>(6) should continue to support the Principles of Medical Ethics concerning fraud by encouraging physicians to accept the responsibility to expose those engaged in fraud and deception;</p> <p>(7) should continue to pursue recent initiatives, including providing assistance to the FBI in a cooperative endeavor as it attempts to identify and prosecute health care fraud, and continue ongoing efforts with the FTC to remove the current legal barriers to professional self-regulatory activity that would assist in the elimination of fraud and abuse;</p> <p>(8) should pursue legislative efforts to enact a program that would award grants to medical societies for the creation of programs specifically targeted at fraud and abuse; and</p> <p>(9) continue to make the relief of oppressive and overzealous application of fraud and abuse regulations a high priority and take whatever action is necessary to challenge improprieties in the application of fraud and abuse laws against physicians.</p> <p>(BOT Rep. Z, I-92; Reaffirmed: Sub. Res. 232, A-96; Reaffirmation A-99; Appended: Sub. Res. 244, A-00; Reaffirmed: Res. 201, I-00; Reaffirmation I-00; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, A-12)</p>	<p>Also, the HOD has adopted more current and relevant policy addressing fraud and abuse since 1992, including:</p> <p>H-175.979, Medicare “Fraud and Abuse” Update;</p> <p>H-175.981, Fraud and Abuse Within the Medicare System;</p> <p>H-175.982, Due Process for Physicians;</p> <p>H-175.984, Health Care Fraud and Abuse Update;</p> <p>H-70.952, Medicare Guidelines for Evaluation and Management Codes</p>
H-180.954	Privacy of Physician Medical Information	<p>It is the policy of the AMA that a physician’s personal medical history is private and should remain confidential. Only information regarding current health status should be required for credentialing purposes.</p> <p>(BOT Rep. 7, I-02; Reaffirmed: CMS Rep. 4, A-12)</p>	Retain – this policy remains relevant.
H-190.960	HIPAA Law and Regulations	<p>Our AMA believes that inadvertent disclosures of protected health information should not lead to the imposition of criminal sanctions.</p> <p>(Sub. Res. 207, A-02; Reaffirmed: CMS Rep. 4, A-12)</p>	Retain – this policy remains relevant.
H-285.909	Designation of Electrodiagnosis / Other Services as Separate	<p>Our AMA will: (1) oppose the re-designation of services traditionally provided by broader medical specialties as a separate specialty category for inclusion into a payor’s provider</p>	Retain – this policy remains relevant.

	Category in Provider Network	network unless compelling evidence shows it will improve patient care; and (2) support the ability for all appropriately trained neurologists and physiatrists to perform electrodiagnosis on patients within their provider network. (Res. 814, I-12)	
H-285.933	Financial Liability Encountered in Referrals for Alternative Care	The AMA supports legislation that managed care organizations that offer alternative medicine as a covered service not require referral by the primary care physician for that service, and that the primary care physician not be held at risk financially for the costs of those provided alternative medical services. (Res. 702, A-98; Reaffirmed: BOT Rep. 36, A-02; Reaffirmed: CMS Rep. 4, A-12)	Retain – this policy remains relevant. Primary care physicians should not be required by health plans to authorize alternative medicine that they do not provide themselves (e.g., acupuncture).
H-30.938	Support for Medical Amnesty Policies for Underage Alcohol Intoxication	Our AMA supports efforts among universities, hospitals, and legislators to establish medical amnesty policies that protect underage drinkers from punishment for underage drinking when seeking emergency medical attention for themselves or others. (Res. 202, A-12)	Retain – this policy remains relevant.
H-335.964	Funding for the Agency for Healthcare Research and Quality	Our AMA: (1) strongly supports the AHRQ in its activities, programs and initiatives designed to provide evidence-based information to evaluate and improve health care in practice settings; and (2) supports legislation that would greatly expand the scope and budget of the AHRQ as the central federal agency coordinating the issues involved in implementing the changes discussed in the IOM report, Crossing the Quality Chasm. (Res. 811, A-02; Appended: BOT Rep. 14, I-02; Reaffirmed: CMS Rep. 4, A-12)	Retain – this policy remains relevant.
H-383.989	Protecting Physicians with Multiple Tax ID Numbers	Our AMA will support legislation and/or regulation to prevent managed care organizations from requiring physicians to participate under all of their Tax ID Numbers if they participate under one Tax ID Number. (Res. 215, A-12)	Retain – this policy remains relevant.
H-385.971	Physician Negotiations with Third Party Payers	The AMA (1) will aid, encourage and guide medical societies in efforts to directly negotiate with any larger payer of medical services; (2) will negotiate with national third party payers with regard to national policies which arbitrarily interfere with patient care; and (3) will use its legal and legislative resources to the maximum extent to change the laws to permit physicians to fairly and collectively deal with third party payers. (BOT Rep. MMM, A-91; Reaffirmation A-97; Reaffirmation I-06; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12)	Retain – this policy remains relevant.
H-435.944	Clinical Decision Support and Malpractice Risk	Our AMA will: (1) advocate in interested states for legislation that would create a “safe harbor” for physicians who use a consensus-based drug-drug interaction list in their clinical decision support software package; and (2) communicate to governmental authorities in	Sunset this policy. This policy was very specific to a policy trend that was occurring in 2012. This has not been an area of recent activity in the states.

		interested states that patients, physicians, hospitals, and the government will all lose out if a “safe harbor” for physicians who use a consensus-based drug-drug interaction list in their clinical decision support software package is not developed. (Res. 228, A-12)	
H-440.859	American’s Health	Our AMA will: (1) make improving health through increased activity and proper diet a priority; (2) propose legislation calling on the federal government and state governments to develop new and innovative programs in partnership with the private sector that encourage personal responsibility for proper dietary habits and physical activity of individual Americans; and (3) continue to work in conjunction with the American College of Sports Medicine, American Heart Association, US Department of Health and Human Services and any other concerned organizations to provide educational materials that encourage a healthier America through increased physical activity and improved dietary habits. (Res. 201, A-09; Reaffirmation A-12)	Retain – this policy remains relevant.
H-478.994	Health Information Technology	Our AMA will support the principles that when financial assistance for Health IT originates from an inpatient facility: (1) it not unreasonably constrains the physician’s choice of which ambulatory HIT system to purchase; and (2) it promotes voluntary rather than mandatory sharing of Protected Health Information (HIPAA-PHI) with the facility consistent with the patient’s wishes as well as applicable legal and ethical considerations. (Res. 723, A-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 237, A-12)	Retain – this policy remains relevant.
H-510.987	Support Integration of Care for Returning Military, Veterans and Their Families by Opening Access to the States’ Prescription Monitoring Programs by VA Prescribing Providers	Our AMA urges the Secretary of the Department of Veterans Affairs to implement procedures allowing and encouraging VA-based health care providers to access and utilize state-based prescription drug monitoring programs in order to improve risk assessment and medical management of their patients receiving prescriptions for controlled substances. (BOT action in response to referred for decision Res. 710, A-12)	Sunset this policy. The AMA has extensive policy regarding the use of PDMPs, including VA-specific provisions within H-95.947 , “Prescription Drug Monitoring to Prevent Abuse of Controlled Substances,” which provides for support for the VA to report prescription information required by the state into the state PDMP; and that physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state.

10. AMERICAN MEDICAL ASSOCIATION CENTER FOR HEALTH EQUITY ANNUAL REPORT

Informational report; no reference committee hearing.

HOD ACTION: FILED

BACKGROUND

At the 2018 Annual Meeting, the House of Delegates adopted Policy D-180.981, 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” and instructing the “Board to provide an annual report to the House of Delegates regarding AMA’s health equity activities and achievements.” The HOD provided additional guidance via Policy H-180.944: “Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.” HOD policy was followed by creation of the AMA Center for Health Equity (“Center”) in April 2019 and the AMA’s Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 (“Plan”) in May 2021.

DISCUSSION

Our AMA has committed itself to advancing health equity, advocating for racial and social justice, and embedding equity across the organization and beyond. While achieving equity takes time, our AMA has raised the profile of health equity in medicine. This garners attention from all over the world. The creation of the Center is one of the most visible manifestations. Leadership and business units (BUs) across the AMA have steadfastly enhanced efforts over recent years to further embed equity in our work. The Plan, the latest major milestone since establishing the Center, serves as a guide for this work. This report outlines the activities conducted by our AMA during calendar year 2021, divided into five strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3) Ensure Equity in Innovation; (4) Push Upstream; and (5) Foster Truth, Reconciliation, and Racial Healing.

Embed Equity

To ensure a lasting commitment to health equity by our AMA, it must be embedded using anti-racism, structural competency, and trauma-informed lenses as a foundation for transforming the AMA’s staff and broader culture, systems, policies, and practices, including training, tools, recruitment and retention, contracts, budgeting, communications, publishing, and regular assessment of organizational change. The following are some of the relevant accomplishments during 2021:

- In May, the AMA released the Equity Strategic Plan to embed racial justice and advance health equity, a three-year enterprise-level roadmap to improving outcomes and care quality for historically marginalized groups. Dr. Madara, CEO, wrote to all employees, urging them to read the Plan and consider how individual roles and responsibilities can contribute to these efforts. AMA employees were informed about adding equity goals to annual performance plans and reviews.
- Following the launch of the Plan, Dr. Madara, Chief Health Equity Officer Aletha Maybank, MD, MPH, and AMA President Gerald E. Harmon, MD, hosted a briefing for employees, including Q&A, with more than 900 employees attending.
- More than 65 percent of employees have participated in the two-day Racial Equity Institute trainings, which provide crucial foundational learning, encourage meaningful dialogue on the topics of equity and race, and promote a common language for health equity.
- Three cross-enterprise workgroups (Communications, Workforce Equity & Engagement, and Sourcing & Contracting) were established to create action plans that addressed the 2020 all-employee equity and engagement survey findings. These plans are being coordinated to aid development of the AMA Enterprise Equity Action Plan for 2022-2024.
- The Enterprise Equity Core Team, with leaders from the Center, Human Resources (HR) and other BUs, formed to support the cross-enterprise equity workgroups and BU equity action teams and monitor progress, succeeding a less formal team of volunteers.
- Every BU established an equity action team and drafted BU-specific action plans for embedding equity starting in 2022. All BU equity action teams field representatives on the enterprise-wide Health Equity Workgroup (HEW) that meets monthly to share best practices and troubleshoot challenges. Equity action teams also fostered

leadership skills within units like JAMA Network who adopted a “grassroots” volunteer approach. The volunteers represented employees from a broad array of departments. Those with a spectrum of management skills and experience were put in a position to form teams, lead collaborative projects, and design learning experiences for all their colleagues.

- The Human Resources (HR) Diversity, Equity, and Inclusion (DEI) Office was established, leading efforts to positively impact organizational culture and shape the employee experience across the enterprise. The Office launched the HR DEI webpage on AMAtoday, the AMA’s intranet portal, providing information on enterprise-wide DEI efforts including details on employee resource groups at the AMA.
- The Embedding Equity Hub was unveiled on AMAtoday, providing a collection of resources for AMA employees. The Embedding Equity community was launched on Yammer, the AMA’s internal social media platform, as a place for employees to share the work that they’re doing within their BUs and across the enterprise to embed equity at all levels.
- Through updates in talent acquisition practices including a new interview guide and methodology, and anonymizing of resumes, our AMA saw increases in people who identify with minoritized or marginalized groups of 12% among new hires (35% to 47%) and 3% among employees at the director level (15% to 18%). This included people who self-identified with one of the following categories: American Indian/Alaskan Native, Asian, Black or African American, Hispanic, Native Hawaiian/Pacific Islander, or two or more.
- New diversity, equity, and inclusion (DEI) editor appointments were completed in nine (9) of 13 JAMA Network journals, the JAMA Network manuscript submission system was updated with a core taxonomy term focused on DEI and 37 supporting terms, and 2 new policy guidelines for editorial staff and editors were developed to guide multimedia and social media publishing.
- The AMA Foundation’s inaugural \$750,000 National LGBTQ+ Fellowship Program grant was awarded to the University of Wisconsin-Madison School of Medicine and Public Health, out of 50 letters of intent, and 13 institutions asked to submit formal proposals.
- During November’s Special Meeting of the House of Delegates (HOD), AMA hosted the virtual Health Equity Forum, beginning with a chat with Heather McGhee, MD, author of *The Sum of Us*, followed by a moderated conversation about the Equity Strategic Plan with well-known, respected equity experts and scholars. HOD members had the opportunity to discuss the Equity Strategic Plan. The forum concluded with an opportunity for HOD members to engage directly with staff from the Center to hear more about their work.
- Produced a dismantling racism in medicine “Future Shock”¹ event for senior management group and other AMA leaders to explore organized healthcare roles and responsibilities.
- The AMA achieved the following reach with health equity content:
 - 8411 total placements and 22.7+ billion traditional and online media impressions through proactive and reactive media opportunities.
 - Published eight AMA Viewpoints focused on our work to address health inequities for marginalized communities.
 - Publication of 38 COVID-19 Update and Moving Medicine video episodes, including a strong focus on vaccine hesitancy and equitable distribution of vaccines.
 - Website traffic for health equity-related content increased 74% to 913,000 visits.
 - Prioritizing Equity series generated 146,000 views on YouTube, a 57% increase.
 - Leveraged over 300 Ambassadors to socialize the Equity Strategic Plan, yielding a social media reach potential of 61,000.
 - The Plan was the most downloaded AMA health equity document at 8,000.
 - Health equity content directly yielded 96 memberships, a 37% increase.
 - The AMA’s equity content engagement via Ambassador Activation app (SMARP) yielded 344,000 social media reach potential, 591 clicks and 252 shares.

Build Alliances and Share Power

Building strategic alliances and partnerships and sharing power with historically marginalized and minoritized physicians and other stakeholders is essential to advancing health equity. This work centers previously excluded voices, builds advocacy coalitions, and establishes the foundation for true accountability. The following are some of the relevant accomplishments during 2021:

¹ Future shock is a concept popularized by sociologist Alvin Toffler of the pace of change exceeding human capacity to adapt: <https://www.bbc.com/news/world-us-canada-36675260>

- With over 300 applicants from across the country, AMA and the Satcher Health Leadership Institute (SHLI) at Morehouse School of Medicine announced the inaugural cohort of 12 physicians for the AMA-SHLI Medical Justice in Advocacy Fellowship.
- The AMA, AMA Foundation, Association of Black Cardiologists (ABC), American Heart Association (AHA), Minority Health Institute (MHI) and National Medical Association (NMA) co-led the national Release the Pressure initiative to reach more than 300,000 Black women, with approximately 50,000 taking the 'Heart Health Pledge' and more than 72,000 watching the video on blood pressure self-measurement.
- Updated Guidance on Reporting Race and Ethnicity in Medical and Science Journals was developed and revised in consultation with 60 external experts and scholars, published in *JAMA* in August, with 56,000 views. JAMA Network is actively participating in Joint Commitment for Action on Inclusion and Diversity in Publishing with 52 organizations and 15,000 journals worldwide.
- Expanded equity focused offerings on AMA Ed Hub with education from the AMA and eight (8) external organizations leading to more than 300,000 views.
- Engaged 69 institutions and groups, securing and promoting virtual screening by at least 6,000 registrants and 1,679 discussion participants for short documentary videos produced by Black Men in White Coats, which seeks to increase the number of Black men in the field of medicine by exposure, inspiration, and mentoring.
- Partnered with the Association of American Medical Colleges (AAMC) and Accreditation Council for Graduate Medical Education (ACGME) to create the Physician Data Collaborative to explore the use of physician data to advance health equity. The Collaborative agreed on race and ethnicity standards, added the Middle Eastern/North African racial category to the work of the three organizations (see Board of Trustees Report 12-A-22 for more detail), and prioritized sexual orientation and gender identity (SOGI) as the next focus for reaching common standards and definitions.

Push Upstream

Pushing upstream requires looking beyond cultural, behavioral, or genetic reasons to understand structural and social drivers of health and inequities, dismantle systems of oppression, and build health equity into health care and broader society. The following are some of the relevant accomplishments during 2021:

- In February and March, a two-part theme issue on “racial and ethnic health equity in the US” was published in the *AMA Journal of Ethics*. During these 2 months, the journal received nearly 700,000 visits and 37,000 PDF downloads.
- Published an editorial on commitment to equity with a 14-point plan across JAMA Network journals (over 200,000 views). *JAMA* published a theme issue on racial and ethnic disparities and inequities in medicine and health care (over 159,000 views). Published 500 additional articles on DEI, health disparities, and health inequities in JAMA Network journals.
- The AMA partnered with HealthBegins on an educational module for physicians on the use of CPT Evaluation and Management codes in identifying social determinants and two open access Steps Forward toolkits, generating more than 15,000 pageviews: (1) Racial and Health Equity: Concrete STEPS for Smaller Practices and (2) Social Determinants of Health (SDOH). This partnership continued with creation of the AMA SDOH work group.
- To improve blood pressure control in communities on the west side of Chicago, AMA collaborated with West Side United and West Side Health Equity Collaborative providing training and education on self-measured blood pressure, and with health care organizations and health centers implementing the AMA MAP BP™ quality improvement program.
- The AMA partnered with the American College of Preventive Medicine and the Black Women’s Health Imperative on a multi-year initiative to increase support for Black and Latinx women to enroll in an evidence-based Diabetes Prevention Program. The AMA worked with physicians to identify patients’ social needs and remove barriers to participation.
- The AMA measured burnout in 27 Federally Qualified Health Centers (more than 1,000 physicians) and held 3 virtual workshops on reducing practice inefficiencies and burnout.
- The AMA, in partnership with the Association of American Medical Colleges (AAMC) Center for Health Justice, published the *Advancing Health Equity: A Guide to Language, Narrative and Concepts* provides guidance and promotes a deeper understanding of equity-focused, person-first language and why it matters.
- The AMA continued advocacy efforts around maternal and child health, particularly inequities in maternal morbidity and mortality.
 - Staff served as a guest speaker during a ReachMD radio podcast; participated on an AMA Advocacy Insights panel discussion; served on a panel discussion for the AMA’s Women Physicians Section membership roundtable; and served as a guest speaker during the annual AMA Medical Student Advocacy Conference.

- Staff developed and continue to update an AMA webpage devoted to amplifying the issue of maternal mortality and morbidity in the U.S. and the AMA's related work.
- New AMA policy on "Reducing Inequities and Improving Access to Insurance for Maternal Health Care" (H-185.917) from Joint CMS-CSAPH Report N-21.
- The AMA proactively engaged with the Administration, Congress, and state policymakers, including:
 - submitting an extensive statement for the record for a Congressional Hearing on the maternal health crisis;
 - supporting an American Rescue Plan Act of 2021 provision for temporary optional expansion of state Medicaid/CHIP coverage one year postpartum;
 - supporting the Mothers and Offspring Mortality and Morbidity Awareness (MOMMA) Act, which uses a six-pronged approach to address and reduce maternal deaths by: establishing national obstetric emergency protocols, ensuring coordination among maternal mortality review committees, standardizing data collection and reporting, improving access to culturally competent care, providing guidance and options for states paying for doula support services, and extending Medicaid coverage to one year postpartum;
 - supporting S. 796 and H.R. 958, the Protecting Moms Who Served Act, signed into law Nov. 30, 2021, requiring the Department of Veterans Affairs to implement the maternity care coordination program with community maternity care providers trained to address the unique needs of pregnant and postpartum veterans and requiring the U.S. Government Accountability Office to report on pregnant and postpartum veteran maternal mortality and severe maternal morbidity with a focus on veteran racial and ethnic disparities in maternal health outcomes; and
 - joining a sign-on letter urging CMS to approve pending Section 1115 demonstration projects extending the postpartum coverage period to a full year for individuals enrolled in Medicaid while pregnant. This advocacy led to CMS approving Illinois' Section 1115 waiver extending coverage.
- The AMA advocated around many policies to advance health equity including:
 - Joining joint letter to Congress in support of H.R. 3746, the Accountable Care in Rural America Act.
 - Submitting letters to Congress in support of: S. 937/H.R. 1843, the COVID-19 Hate Crimes Act; H.R. 955/S. 285, the Medicaid Reentry Act; and sustainable Medicaid funding for Puerto Rico and other U.S. territories.
 - Submitting letters to Departments of Justice, Labor, and Homeland Security (DHS) / Citizenship and Immigration Services (CIS) on: White House Immigration Regulatory Reviews, uninformed DHS public health determinations denying asylum, Alternatives to Detention, Haitian refugee health, Public Charge Rule, Procedures for Credible Fear Screening, and DACA.
 - Submitting letters supporting our IMG membership on: modifications to the H-1B petitions, the Healthcare Workforce Resilience Act, wage protections for H-1B and J-1 physicians, Barriers Across USCIS Benefits and Services, and the Conrad State 30 and Physician Access Reauthorization Act.
 - Submitting letter to FEMA urging equitable vaccine distribution.
- The AMA created additional new policies on anti-racism in medicine including:
 - Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions, H-65.951
 - Underrepresented Student Access to US Medical Schools, H-350.960

Ensure Equity in Innovation

The AMA is committed to ensuring equitable health innovation by internally and externally embedding equity in innovation, centering historically marginalized and minoritized people and communities in development and investment, and collaborating across sectors. The following are some of the relevant accomplishments during 2021:

- The AMA developed a health equity self-assessment tool for technology-based products or projects and used it on a current major AMA Innovations project, Verifi Health SMBP.
- As part of the DEI program for the Current Procedural Terminology (CPT) code set, AMA launched the Capstone course. In the Innovator Track, entrepreneurs, developers, and innovators learned about the CPT process and related DEI plans. The course has been provided to several external technology and innovation entities.
- As part of the AMA ChangeMedEd 2021 national conference, the AMA sponsored a Bright Ideas Showcase and solicited "blue sky" ideas to improve diversity and address structural racism across the medical education continuum. From 145 ideas received, 25 were selected to be presented, with attendees selecting three to each receive \$20,000 AMA planning grants.
- Integrated Web Content Accessibility Guidelines (WCAG) standards, increasing accessibility for AMA education on AMA Ed Hub, impacting over 250 new activities.

- Nearly 300 activities evaluated for publication on the AMA Ed Hub according to newly created quality review rubric with an equity emphasis.
- In collaboration with the Gravity Project for Social Determinants of Health, AMA contributed to the publication through Health Level Seven® International (HL7®) a FHIR® implementation guide for the capture and use of SDOH data.

Foster Truth, Reconciliation & Racial Healing

The AMA recognizes the importance of acknowledging and rectifying past injustices in advancing health equity for the health and well-being of both physicians and patients. Truth, reconciliation, and racial healing is a process and an outcome, documenting past harms, amplifying and integrating narratives previously made invisible, and creating collaborative spaces, pathways, and plans. The following are some of the relevant accomplishments during 2021:

- The Prioritizing Equity series launched to illuminate how COVID-19 and other determinants of health uniquely impact marginalized communities, public health, and health equity. It has generated 146,916 views on YouTube.
- Five (5) AMA conference rooms (Washington, Lincoln, Rushmore, Mount Vernon, and Monticello) were previously named with presidential themes, mostly people or places connected to ownership of enslaved Africans. A team of five AMA staff collaborated on themes and options for renaming the rooms, landing on additional American landmarks: Rockies, Acadia, Rio Grande, Everglades, and Great Lakes.

Challenges and Opportunities

Commonly noted challenges included the ongoing COVID-19 pandemic, which created competing demands among staff and partners and required creativity in converting in-person activities to virtual alternatives that promoted robust engagement. Time needed for meaningful learning, relationship development, planning, and project implementation related to health equity were at times greater than anticipated, adding to existing work. Staff noted that uncomfortable conversations and uncertainty about next steps became easier as learning and collaboration continued.

Many staff were eager to learn more about the equity aspects of their work and to find new strategies to address and advance them. Externally supported training and facilitated safe spaces for frank conversations among coworkers helped staff gain a new level of appreciation and understanding for one another and health equity. The Health Equity Workgroup (HEW), the Center, and external partners provided invaluable expertise in crafting and updating initiatives. Commitments from leadership, clear policy on health equity, and building on existing relationships across the enterprise and with external partners supported progress.

CONCLUSION

AMA staff were asked for their most prominent equity-related accomplishments, and not everything submitted could be included in this report, so the above represents a fraction of the work completed in 2021. Based on submitted accomplishments AMA mobilized at least 560 staff, collectively contributing more than 54,000 hours (or at least 30 full-time equivalents) to advance equity. Overall, AMA has made significant progress towards fulfilling the commitments outlined in the Plan during its first official year.

APPENDIX

Table 1: Approaches, Commitments, Quarters, Staff, and Hours (Partial List)

Strategic Approach	Commitment	Quarter(s)				Staff	Hours
		1	2	3	4		
1. Embed racial and social justice throughout the AMA enterprise culture, systems, policies, and practices	a. Build the AMA's capacity to understand and operationalize anti-racism and equity strategies via training and tool development	1	2	3	4	383	12163
	b. Ensure equitable structures and processes and accountability with prioritization on the AMA's workforce, contracts/sourcing and communications	1	2	3	4	90	4018
	c. Integrate trauma—informed lens and approaches	1	2	3	4	69	670
	d. Assess organizational change (culture, policy, process) over time	1	2	3	4	146	1795
2. Build alliances and share power with historically marginalized physicians and other stake holders	a. Develop structures and processes to consistently center the experiences and ideas of historically marginalized (women, LGBTQ+, people with disabilities, International Medical Graduates) and minoritized (Black, Indigenous, Latinx, Asian) physicians	1	2	3	4	1	800
	b. Establish a national collaborative of multidisciplinary, multisectoral equity experts in health care and public health to collectively advocate for justice in health	1	2	3	4	15	3900
3. Push upstream to address all determinants of health and the root causes of health inequities	a. Strengthen physicians' understanding of public health and structural/social drivers of health and inequities	1	2	3	4	189	270
	b. Empower physicians and health systems to dismantle structural racism and intersecting systems of oppression						
	c. Equip physicians and health systems to improve services, technology, partnerships and payment models that advance public health and health equity	1		3	4	22	7070
	a. Embed equity within existing AMA health care innovation efforts		2	3	4	26	346
4. Ensure equitable structures and opportunities in innovation	b. Equip the health care innovation sector to advance equity			3	4	5	425
	c. Center and amplify historically marginalized and minoritized health care investors and innovators						
	d. Engage in cross-sector collaboration and advocacy efforts						
	a. Amplify and integrate often “invisible-ized” narratives of historically marginalized physicians and patients in all that we do				4	4	240
5. Foster truth and racial healing, reconciliation and transformation for the AMA's past	b. Quantify impacts of AMA's policy and process decisions that excluded, discriminated and harmed			3		8	160
	c. Repair and cultivate a healing journey for those who have been harmed	1		3	4	27	710

Table 2: External Partners

Accelerating Change in Medical Education (ACE) Consortium members	Accreditation Council for Graduate Medical Education (ACGME)	Ad Council
Adelante Healthcare	Albert Einstein College of Medicine	Alliance Chicago
American College of Preventive Medicine (ACPM)	American Heart Association	American Telemedicine Association (ATA) EDGE
Anytime Health	Arizona Alliance	Association of American Medical Colleges (AAMC)
Association of Black Cardiologists	Authority Health	Baylor College of Medicine
Black Men in White Coats	Black Women's Health Imperative	Boston Children's Hospital
Canyonlands Healthcare	Capital Region Medical Center	Center for Care Innovations
Centers for Disease Control and Prevention (CDC)	Chiricahua Community Health Centers, Inc.	Circle the City
Columbia University	Community Health Centers of Yavapai	Copper Queen Community Hospital
COVID Black	Creek Valley Health Clinic	Des Moines University
Desert Senita Community Health Center (CHC)	Diversity Lab (Mansfield Rule, Legal Department Edition)	Eastern Virginia Medical School
El Rio Health	Emory School of Medicine	Erie Family Health Centers
Florida International University	Gardeneers	Gartner
George Washington University Fitzhugh Mullan Institute for Health Workforce Equity	George Washington University School of Medicine	Gravity Project
Harvard Medical School / Massachusetts General Hospital (MGH) / Beth Israel Deaconess Medical Center (BIDMC)	Health Level Seven (HL7) International	HealthBegins
Heartland Health Centers	Highland Hospital	Horizon Health and Wellness
Howard Brown Health	Jacobs School of Medicine and Biomedical Sciences University at Buffalo	Johns Hopkins Medicine
Johns Hopkins University	Joint Commitment for Action on Inclusion and Diversity in Publishing	Kaiser Permanente Bernard J. Tyson School of Medicine
K'ept Health	Loma Linda University School of Medicine	Loyola University of Chicago
Mariposa Community Health Center	Mass Challenge Health Tech	MATTER
Mayfield	Mayo Clinic Alix School of Medicine	MedTech Color
MHC Healthcare	Minority Health Institute	Morehouse School of Medicine
Mountain Park Health Center	National Alliance on Mental Illness (NAMI)	National Digital Inclusion Alliance
National Medical Association	Native Americans for Community Action	Native Health
Neighborhood Outreach Access to Health	New York University (NYU) Grossman School of Medicine	North Country Healthcare
Northwestern University	Nursing Innovation Hub	Ohio State University
Per Scholas	Perelman School of Medicine at the University of Pennsylvania	Public Health Innovators
Raben Group Consulting	Racial Equity Institute (REI)	Radical Health
Rutgers New Jersey Medical School	Shasta Community Health Center Family Medicine Residency Program	Stanford University Byers Center for Biodesign
Stanford University School of Medicine	Sun Life Family Health Center	Sunset Community Health Center
TEKsystems	Telehealth Academy	Terros Health

Texas Medical Center (TMC) Innovation Health Tech Accelerator (formerly TMCx)	The Exeter Group	The Warren Alpert Medical School of Brown University
Thomas Jefferson University Hospital	Thomas Jefferson University, Sidney Kimmel Medical College	Together.Health
Tulane	United Community Health Center	University of Alabama at Birmingham
University of California (UC) Davis School of Medicine	University of California San Francisco (UCSF)	University of California San Francisco (UCSF) School of Medicine
University of Charleston	University of Connecticut School of Medicine	University of Illinois Chicago
University of Illinois Chicago College of Medicine	University of Illinois Chicago College of Nursing	University of Michigan Medical School
University of North Carolina School of Medicine	University of Southern California (USC)	University of Southern California (USC) Keck School of Medicine
University of Southern California (USC) Price School of Public Policy	University of Texas Health Science Center at Houston (UT Health Houston) McGovern Medical School	University of Texas Health Science Center at San Antonio (UT Health San Antonio)
University of Toledo College of Medicine and Life Sciences	University of Utah School of Medicine	University of Washington School of Medicine
Urban Alliance (High School Summer Internship Program)	Valle del Sol	Valleywise Health and District Medical Group
Wesley Health Center	West Side Health Equity Collaborative	West Side United
Willis Towers Watson (WTW)	Yale School of Medicine	

11. PROCEDURE FOR ALTERING THE SIZE OR COMPOSITION OF SECTION GOVERNING COUNCILS

Reference committee hearing: see report of Reference Committee F.

**HOD ACTION: RECOMMENDATIONS NOT ADOPTED
REMAINDER OF REPORT FILED**

INTRODUCTION

In 2021, the Medical Student Section (MSS) Assembly adopted a resolution to amend the MSS Internal Operating Procedures (IOPs) to expand the MSS Governing Council by addition of a new position. Pursuant to existing rules, the MSS submitted this proposed revision for review and approval by the Board of Trustees.

While the Board ultimately approved the request, believing the proposed alteration to be in the best interest of both the Section and the Association, the Board's deliberation on this matter raised a critical question: should the Board of Trustees continue to possess the authority to approve alterations to the size and composition of Section Governing Councils, or would this authority be more properly entrusted to the House of Delegates?

BACKGROUND

Currently, the size and composition of section governing councils are codified in the IOPs of each section. The AMA bylaws do not dictate the size of section governing councils; nor do they codify the composition of section governing councils beyond simply requiring that each have a chair and a vice chair/chair-elect (AMA Bylaw 7.0.4). Instead, the bylaws state that "Each Section shall adopt rules governing the titles, duties, election, term, and tenure of its officers" (AMA Bylaw 7.0.4.3), which, along with any other IOPs, are subject to Board review and approval (AMA Bylaw 7.0.7) with advice from the Council on Constitution and Bylaws (CCB) (AMA Bylaw 6.1.1.4).

Accordingly, under current AMA governance rules, a section request to change the size of its governing council or the composition of its governing council outside of chair/vice chair/chair-elect need only be approved by the Board. But this has not always been the case. Previously, the bylaws described in detail the structure and function of each section, including the size and composition of section governing councils. As such, revisions to section structure and function, no matter how mundane, typically required amendments to the bylaws, which had to be approved by the House of Delegates.

In 2006, CCB conducted a comprehensive review of the constitution and bylaws, seeking to improve the language and structure of these documents and to ensure that they accurately reflected the organization as it had evolved. This effort culminated in the adoption by the House of Delegates of the recommendations in CCB Report 2-I-06, "Revisions to AMA Bylaws." In adopting those recommendations, the House of Delegates removed much of the section-related detail from the bylaws, including descriptions of the size and detailed composition of section governing councils. The remaining section-related bylaws content included a framework description of each section and an overarching description of the sections (AMA Bylaws 7.0.1-7.0.9), which vested in the Board the responsibility to review the rules, regulations, and procedures adopted by each section (i.e., IOPs). Notably, these revisions did not eliminate bylaws provisions fixing the size and core composition of the seven AMA Councils, which therefore remain to this day the province of the House of Delegates.

While not addressed in the body of the CCB report, the impetus for moving section-related detail from the bylaws to IOPs was to remove the burden on the House of Delegates of constant review and approval of internal section matters—for example, election rules, policymaking procedures, etc. It is not clear whether CCB, the House of Delegates, or the sections explicitly contemplated whether the size and composition of a section governing council ought to be subject to review by the House of Delegates, or whether this detail was simply swept from the bylaws along with other details in a very long CCB recommendation.

DISCUSSION

Your Board believes that the size and at least some detail about the composition of section governing councils should be subject to review and approval by the House of Delegates. Such provisions are a critical piece of the AMA

governance framework, and their current positioning under the authority of the Board seems an anomaly compared to other oversight of the sections. In particular, the House of Delegates is responsible for establishing new sections, and for renewing section status for delineated sections, via a review facilitated by the Council on Long Range Planning and Development (CLRPD). In the case of both a new section and renewal of delineated status for an existing section, this review specifically examines whether “the structure of the group [is] consistent with its objectives and activities” (AMA Policy G-615.001). The Board’s current oversight of the size and composition of section governing councils is also an anomaly compared to oversight of other AMA governance groups. Specifically, as noted above, the House of Delegates has the sole authority to change the size and core composition of AMA Councils.

Your Board recognizes the wisdom of not codifying every section governance detail in the bylaws, fearing that such action would require the House of Delegates to expend inordinate effort on discussion of section governance revisions. We also recognize the need for flexibility and timeliness as sections seek to revise peripheral aspects of their governance to streamline their operations and thereby augment their impact. For these reasons, your Board proposes a middle-ground solution in which the House of Delegates would reclaim authority to approve revisions with fiscal impact (e.g., adding a member) or that alter core governing council membership (i.e., chair cycle, delegate/alternate delegate), while the Board would retain authority to approve alterations to non-core governing council positions (e.g., transforming a member at-large position into a vice speaker position). This transfer of authority would be accomplished by amending the bylaws to include the current size and core composition of each section governing council, making any future changes in these areas subject to House of Delegates approval. Additionally, given the complexity of these governance matters and CLRPD’s existing oversight of the sections, your Board recommends that CLRPD play a central role in developing criteria for the consideration of and reviewing future requests to alter the size or core composition of section governing councils.

RECOMMENDATION

Your Board of Trustees recommends that the following recommendations be adopted and that the remainder of this report be filed:

1. That AMA Bylaws be amended to include the size and core composition (chair cycle, delegate/alternate delegate) of each section governing council.
2. That the Council on Long Range Planning and Development develop criteria for reviewing requests to alter the size or core composition (chair cycle, delegate/alternate delegate) of section governing councils.
3. That the Council on Long Range Planning and Development be assigned responsibility for reviewing and making recommendations to the House of Delegates as to the disposition of any request to alter the size or core composition (chair cycle, delegate/alternate delegate) of a section governing council.

12. DISAGGREGATION OF DEMOGRAPHIC DATA FOR INDIVIDUALS OF MIDDLE EASTERN AND NORTH AFRICAN (MENA) DESCENT

Informational report; no reference committee hearing.

HOD ACTION: FILED

BACKGROUND

Racial and ethnic categories are socially constructed, differ between countries and vary significantly over time.¹ Categories evolve as a result of political circumstances and social demands, and they are more fluid than most people perhaps recognize. For example, it was not until the 1980 U.S. Census that Hispanic/Latino was recognized as an ethnicity.² The process by which categories are officially recognized in the U.S. is complex; as Germaine Awad et al note, the process reflects political motivations ranging from “remediating inequalities to advancing White supremacist values.”³ The former is done when categories are used to identify, measure, and track inequities; the latter has historically been used to define and uphold “whiteness” in political and social discourse.^{1,4}

A group that has been omitted--and thus rendered invisible--in many medical and social data collection systems is the Middle Eastern and North African (MENA) population.^{3,5-7} This invisibility perpetuates a cycle of largely unacknowledged health inequities affecting this diverse population.^{7,8}

The current practice of the U.S. Census Bureau is to include the MENA population in its definition of “white”: “a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.” In this regard, the U.S. is alone among North American and European countries that collect population-level data on race and ethnicity in counting MENA individuals as “white.”⁹ * This has been the practice of the US Census Bureau since the early 20th century.⁶ According to Sarah Jonny, “Fearing harsh limitations on immigration, Lebanese and Syrian immigrants wished to be omitted from the Asian Exclusion Act of 1924, which blocked Asian immigration to the United States and therefore lobbied Congress to be identified as Caucasian.”⁶

Groups like the Arab American Institute have been advocating since the 1980s for changes to the U.S. Census. MENA activists have argued for the creation of a MENA identity category separate from the white category, based on the notion that including people of MENA descent within the white category erases and renders invisible the needs of this group.⁷ Jonny observes: “...the white category became too restrictive and prevented MENA individuals from understanding their population’s trauma.”⁶ And Neda Maghjbouleh et al point out: “In making their case, activists argued that MENA populations are not actually perceived by others in the United States as White. They have suggested that September 11, 2011 (9/11), the War on Terror, and increasingly divisive rhetoric in the United States political campaigns further differentiated this group from Whites, leading to discriminatory experiences. ...[This is an issue hampered by] the invisibility of this population in administrative data.”⁹ From this perspective, the lack of official data renders “invisible the unique challenges faced by Arab/MENA populations.”³ Some commentators have labelled this a form of structural violence.⁸

It was not until 2010 that the U.S. Census Bureau undertook a national study to investigate the need for a separate MENA category. After 67 focus groups with over 700 participants from across the U.S., the Bureau concluded that it was “inaccurate” to count the MENA population within the “white” category.¹⁰ The Census Bureau further studied this issue in the 2015 National Content Test (NCT), which tested options for the inclusion of a MENA category.¹ By 2017 the U.S. Census Bureau concluded that it would be “optimal” to use a category dedicated to MENA, because fewer people would select “some other race” and would see their identity reflected in the questionnaire.⁶ However, the Trump Administration rejected the Census Bureau’s recommendation, called for more research on the issue, and as a result a MENA option was not added to the 2020 Census.⁶ In 2018, the Bureau noted public feedback from “a large segment of the MENA” population who advocated for the category to be considered an ethnicity, rather than a race.¹¹ The Census Bureau continues to study the inclusion of MENA as an option for the 2030 Census.¹²

The MENA population in the U.S. is comprised of at least 19 different nationalities and 11 ethnicities, with varying histories of immigration and acculturation in the U.S.⁹ Absent from official data collection systems, “the MENA population has been undercounted and disadvantaged in terms of acquiring services that could benefit this group.”^{1,13}

While the 2010 Census generated an estimate of 1.9 million Arab Americans living in the U.S., the Arab American institute suggests that this number is closer to 3.7 million, with many respondents indicating “some other race” rather than “white.”^{6,8} Indeed, in both the 2000 and the 2010 Census, “some other race” was the third largest “race” group.¹ Randa Kayyali notes: “like Hispanics, Arabic-speaking people relate to and can be identified racially from ‘black’ to ‘white’ or can be classified as Asian or African if accounted for according to continental origins.”¹³

In 2016, the Association of American Medical Colleges (AAMC) took the position of advocating for the including of MENA as a separate category, distinct from “white,” in federal data collection efforts. The AAMC noted: “Americans of Middle Eastern and North African descent, a group currently aggregated in the “White race alone” category, experience health and health care inequities. In order to maximize the documentation of disparities relevant to this population, AAMC fully supports creating a separate subcategory for Middle Eastern/ North African (MENA) respondents to more adequately reflect their self-identity.”¹⁴

Our AMA now advocates for the inclusion of MENA as a separate racial category on all AMA demographics forms and the use of MENA as a separate race category in all uses of demographic data including but not limited to medical

* Throughout this report, we follow AP guidelines to lower case white, except when white was capitalized in a quoted source (see the AMA – AAMC Center for Health Justice’s *Advancing Health Equity: A Guide to Language, Narrative and Concepts* for additional discussion).

records, government data collection and research, and within medical education. In this way, AMA policy is now better aligned with the AAMC's position. Moreover, the AMA supports the study of methods to further improve disaggregation of data by race which most accurately represent the diversity of patients. This builds upon existing AMA policy supporting the disaggregation of demographic data for Asian-American and Pacific Islander (AAPI) populations.

Last, the federal government's Health Information Technology (health IT) Certification Program requires that all certified electronic health record (EHR) systems have the ability to collect an individual's race and ethnicity data based on the United States (U.S.) Centers for Disease Control and Prevention (CDC) coding system guidelines. Nearly all physicians and hospitals utilize certified health IT and EHRs in their practice. The CDC's code set is based on current federal standards for classifying data on race and ethnicity, specifically the minimum race and ethnicity categories defined by the U.S. Office of Management and Budget (OMB) and a more detailed set of race and ethnicity categories maintained by the U.S. Bureau of the Census. The main purpose of the code set is to facilitate use of federal standards for classifying data on race and ethnicity when these data are exchanged, stored, retrieved, or analyzed in electronic form. There are over 900 specific codes representing race and ethnicity. *Middle Eastern or North African* is a recognized code concept within the CDC code system (e.g., Concept Code 2118-8).¹⁵

As part of the federal government's certification program, EHRs are required to be able to record multiple races or ethnicities reported by a patient. For reporting purposes, EHRs are also required to be able to consolidate an individual's chosen race and ethnicity data into one or more OMB categories.[†] Health IT certification requirements do not specify which race and ethnicity codes must be supported by default, only that the minimum OMB categories are enabled. For example, an EHR vendor may choose to make only the core OMB categories active by default when installing an EHR in a medical practice. However, to pass federal certification requirements, all EHRs must have the ability to capture any and all CDC and OMB category codes. Some EHR products may not automatically enable specific race and ethnicity codes, but each product must support the entire CDC code system upon customer request.

Considerations

Some researchers have expressed concern that adding MENA as a separate category may have negative unintended consequences, including increased surveillance and policing of the MENA population in the U.S.^{1,16} Khaled Bedyodun, for example, warns that "the proposed MENA box will facilitate War on Terror policing... [and] will chill constitutionally protected activity and further curb the civil liberties of Arab Americans."¹⁷ Yet while this concern is acknowledged in the literature by other commentators, more weight has been given to the benefits of overcoming data invisibility for the MENA population in the U.S.^{3,8,13} As noted by Hephzibah Strmic-Pawl et al, "it is important to trace race in order to track racism"¹—and without clear data, the needs of this community will never be fully understood or addressed.

Chandra Ford, a leading expert on critical race theory and public health data, has also written about the need to take this opportunity to not only refine racial/ethnic categories and bolster data collection systems, but to investigate and acknowledge the central concepts of white supremacy, whiteness, and white privilege in data collection and analysis.¹⁶ Ford and her colleague Mienah Sharif note that this is an "opportunity to offer guidance to the NIMHD [National Institute on Minority Health and Health Disparities] about the types of data that are needed to distinguish data that enable antiracism research from those that may further marginalize these populations."¹⁶ Such advice is also relevant to our AMA. Ford and Sharif also urge caution, noting that there exists the risk of unintended harms from any additional surveillance efforts.

There are also significant and ongoing debates about how to best include MENA as an option in demographic forms. Indeed, there are some suggestions that the term is not the most appropriate to use, given the colonial roots of the term "Middle East." Activists, including the SWANA Alliance (<https://swanaalliance.com>) advocate for the use of SWANA – South West Asian/North African – as a decolonial term in place of Middle Eastern, Near Eastern, Arab World or more.

In the peer-reviewed literature, the latest and most authoritative piece from Awad et al outlines three options for the collection of MENA data (derived from the Census Bureau's NCT):

[†] The OMB standards have one category for ethnicity—Hispanic or Latino—and five minimum categories for data on race. This includes Ethnic Categories: Hispanic or Latino and Racial Categories: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White.

Option 1: A streamlined/combined question. Respondents would be instructed to mark all boxes that apply (allowing for multiple race/ethnicity combinations).

Option 2: Separation of ethnicity and race. This would treat MENA as an ethnicity, akin to Hispanic/Latino in many forms.

Option 3: Adding a separate MENA category. This option would enable data collection instruments that are restricted to OMB categories to collect additional data. The 2020 Michigan Behavioral Risk Factor Surveillance System included this option.³

These three options are depicted in Figure 1:

Option 1:

What is the person's race or origin?

Mark all boxes that apply AND print origins in the spaces below. Note, you may report more than one group.

☐ **White** – Print, for example, German, Irish, English, Italian, Polish, French, etc.

☐ **Hispanic, Latino, or Spanish origin** – Print, for example, Mexican or Mexican American, Puerto Rican, Cuban, Salvadoran, Dominican, Colombian, etc.

☐ **Black or African Am.** – Print, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.

☐ **Asian** – Print, for example, Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, etc.

☐ **American Indian or Alaska Native** – Print, for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc.

☐ **Middle Eastern or North African** – Print, for example, Lebanese, Iranian, Egyptian, Syrian, Moroccan, Algerian, etc.

☐ **Native Hawaiian or Other Pacific Islander** – Print, for example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.

☐ **Some other race of origin** – Print race or origin.

☐ **Multi-Racial** – Print race(s) or origin(s).

Option 2:

Is the person of Hispanic, Latino, or Spanish origin?

Mark one or more boxes AND print origins.

☐ **No**, not of Hispanic, Latino or Spanish Origin

☐ **Yes**, Mexican, Mexican Am., Chicano

☐ **Yes**, Puerto Rican

☐ **Yes**, Cuban

☐ **Yes**, another Hispanic, Latino or Spanish origin – Print, for example, Salvadoran, Dominican, Colombian, Guatemalan, Spaniard, Ecuadorian, etc.

Is the person of Middle Eastern or North African origin?*Mark one box AND print origins.*

- ☐ **No**, not of Middle Eastern or North African Origin
- ☐ **Yes** – Print, for example, Lebanese, Iranian, Egyptian, Syrian, Moroccan, Algerian, etc.
-

What is the person's race?*Mark one or more boxes AND print origins.*

- ☐ **White** – Print, for example, German, Irish, English, Italian, Polish, French, etc.
-
- ☐ **Black or African Am.** – Print, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.
-
- ☐ **American Indian or Alaska Native** – Print, for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc.
-
- ☐ **Asian** – Print, for example, Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, etc.
-
- Option 3:
- ☐ **Middle Eastern or North African or Arab** – Print, for example, Lebanese, Iranian, Egyptian, Syrian, Moroccan, Algerian, etc.
-

Source: Awad GH, Abuelezzam NN, Ajrouch KJ, Stiffler MJ. Lack of Arab or Middle Eastern and North African Health Data Undermines Assessment of Health Disparities. *Am J Public Health*. 2022;112(2):209-212.

There is currently no consensus on which of these options is optimal, and context will always matter. But the basic goal of including an option for collecting data on MENA origin has gained a lot of momentum. Awad et al note that “Given that the reason for the lack of an Arab/MENA category is likely associated with politics as opposed to science [referring to the science of data collection, not race as a scientific category], it is imperative that researchers and practitioners take the initiative to include this group in data collection.”³ The absence of a MENA option will further perpetuate the invisibility of the needs of this diverse group.

IMPLEMENTATION

Our AMA is developing a collaboration with the AAMC to study the implications of adding MENA as a racial category in one of our most important data assets, the AMA Physician Masterfile (“the Masterfile”). Initially built in 1906, the Masterfile contains current and historical training and professional certification data for approximately 1.4 million physicians (MD and DO), residents, and medical students throughout the U.S. These records are maintained into perpetuity. Medical schools and other physician organizations, federal agencies, and research institutions rely on the Masterfile as a valid and reliable source of information about our nation’s physician workforce and their competencies.

Until recently, the Masterfile did not provide a comprehensive demographic breakdown of our nation’s physicians, the languages they speak, the patient communities to whom they deliver care, or other considerations from which entities can derive a cultural context that bears on the differential health needs of patients across diverse American communities. However, in the past two years, working in collaboration with the AAMC and the Accreditation Council for Graduate Medical Education (ACGME), our AMA has made strides to improve our collection of race and ethnicity data. Our collaboration with the AAMC and the ACGME includes a pilot test of the mechanisms and implications of adding MENA as a separate category of racial/ethnic identity in the Masterfile. The pilot test may need several years of data to generate meaningful results.

Our AMA routinely collects survey data from physicians, and these surveys differ in their approach to defining and collecting race/ethnicity data. The AMA Physician Benchmark Survey, for example, currently does not directly collect race/ethnicity; but individual-level records could be matched to the AMA Physician Masterfile, with valid data from the Masterfile merged into the Physician Benchmark Survey dataset. In 2020, our AMA initiated a cross-sectional Minoritized and Marginalized Physician Survey (MMPS). The MMPS did not include MENA as a racial or ethnic option, instead using the categories of American Indian or Alaska Native, Asian, Black or African-American, Latinx or Hispanic, Native Hawaiian or Pacific Islander, white, or two or more races.

Recognizing the need for clarity and consistency in categories used across AMA demographic data collection, our AMA will study methods for reviewing and standardizing racial/ethnic categories in all AMA demographic forms as part of an AMA-wide “Data for Equity” review described in our AMA Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, to be completed in 2023.¹⁸

Moving forward, we propose several approaches for studying methods and strategies for disaggregation of data by race/ethnicity to most accurately represent the diversity of patients and the physician workforce.

1. The most critical, as discussed above, is a pilot test of the inclusion of a MENA category in the Masterfile. We will collaborate closely with the AAMC on this initiative, since they have already begun work on this, comparing data from the American Medical School Application Service (AMCAS), which uses the standard OMB categories, with data from the AAMC Matriculating Student Questionnaire (MSQ), given annually to all first-year medical students, and which now includes a MENA option. This pilot test will enable us to quantify the effects of adding a MENA option, and the implications it has for other racial/ethnic categories. This may have profound implications for our understanding of the diversity of the physician workforce.
2. A parallel area of research will involve a structured review of empirical studies in medical journals, focusing on quantifying the extent to which they report MENA as a disaggregated category and how this may change over the coming years as more data sources include a MENA option. It is important to do this, because if MENA data are collected but not published, the end result will be a continued invisibility for this diverse group. This would be supported by tracking developments with federal standards, post 2020 Census discussions and publications, as well as outreach to MENA advocates. Time is needed to see which of the three options (or others that may be developed) described above gain traction. This will be an opportunity to continue to listen to the MENA population and respond to its needs.
3. We will conduct outreach to EHR vendors and/or the EHR vendor trade association (e.g., EHRA) in order to better understand the process vendors use to enable or activate race and ethnicity data collection in accordance with federal health IT certification requirements. We will also encourage physicians to reach out to their EHR vendors and inquire about their vendor’s ability to enable or activate CDC-level race and ethnicity data capture.

This work could inform AMA efforts to provide culturally sensitive/appropriate education to patients and clinicians about why this data collection is important. Our efforts will emphasize how the data should/should not be used, both internally and with respect to sharing with third parties in and outside of the healthcare system, and the importance of having policies and procedures in physician practices for how to collect the information and what to do if someone does not want to provide answers. These efforts would be further guided by our general stance on privacy and position that efforts by the government to collect such data must include assurances that the data will not be used against individuals (e.g., not shared with immigration/DHS/DOJ authorities for law enforcement purposes), will be appropriately secured, and will not be used to withhold benefits or social services.

CONCLUSION

There are substantial and ongoing debates pertaining to the inclusion of a MENA option in data collection systems. As of February 2022, there are at least three viable options being debated in the peer-reviewed literature for how to best operationalize the inclusion of MENA as a distinct category in demographic forms. The US Census Bureau continues to research this issue. Our AMA is actively collaborating with the AAMC on a pilot test of the inclusion of a MENA category for medical students and physicians, and our AMA is committed--through our Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity--to a “Data for Equity” review that could be tasked with advancing the study and implementation of best practices for the collection of MENA data.

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APPENDIX: RELEVANT AMA POLICY

AMA policy provides that AMA will: (1) add "Middle Eastern/North African (MENA)" as a separate racial category on all AMA demographics forms; (2) advocate for the use of "Middle Eastern/North African (MENA)" as a separate race category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education; and (3) study methods to further improve disaggregation of data by race which most accurately represent the diversity of our patients. (Policy D-350.979, "Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent").

AMA will continue to work with the Association of American Medical Colleges to collect race/ethnicity information through the student matriculation file and the GME census including automating the integration of this information into the Masterfile. (Policy D-630.972, "AMA Race/Ethnicity Data").

AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology. AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice. AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category "race" can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities. AMA recommends that clinicians and researchers focus on

genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease. (Policy H-65.953, “Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice”).

AMA encourages the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race, ethnicity and preferred language. (Policy H-315.963, “Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities”).

AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine. AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine. (Policy H-350.954, “Disaggregation of Demographic Data Within Ethnic Groups”).

Last, AMA will develop a plan with input from the Minority Affairs Section and the Chief Health Equity Officer to improve consistency and reliability in the collection of racial and ethnic minority demographic information for physicians and medical students. (Policy D-350.982, “Racial and Ethnic Identity Demographic Collection by the AMA”).

13. “USE OF PSYCHIATRIC ADVANCE DIRECTIVES” (RESOLUTION 1-I-19)

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

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy H-140.826

At the 2019 Interim Meeting, the American Medical Association (AMA) House of Delegates referred to the Board of Trustees Resolution 1-I-19, “Support for the Use of Psychiatric Advances Directives,” which was introduced by the Medical Student Section. Resolution 1-I-19 asked:

That our American Medical Association support efforts to increase awareness and appropriate utilization of psychiatric advance directives.

Testimony supported referral of the resolution. Speakers noted that the use of psychiatric advance directives (PAD) is a complex issue that requires study of situations where PADs may be overridden, such as directives that are not aligned with standards of care or patients who pose a risk to public safety. This report reviews evidence currently available in this area from governmental agencies, academic institutions, and scholarly and popular publications.

DEFINITION & BACKGROUND

Psychiatric advance directives (PADs) are legally binding documents (with certain exceptions as noted below) that allow psychiatric patients to direct, while they are well, future decisions about mental health care should they lose the ability to do so due to their psychiatric illness [1]. Such directives may specify but are not limited to, patient preferences regarding types of medications, seclusion and/or restraints, and electroconvulsive therapy. PADs also include the designation of a surrogate decision maker or health care proxy [2]; who ideally works with the patient and physician to complete the PAD.

Studies suggest that “if given the choice and necessary assistance, one-half to one-third of patients with severe mental illness would complete a psychiatric advance directive” [3]. Use of PADs is supported by several mental health and patient advocacy organizations, including the [National Alliance on Mental Illness](#) (NAMI), [Mental Health of America](#), and the [National Coalition for Mental Health Recovery](#). These organizations emphasize the value of PADs for patient

autonomy and self-determination. As NAMI explains, “PADs help an individual with mental illness preserve their autonomy while ensuring the right care at the right time,” while also helping to prevent “involuntary treatment.”

Nonetheless, only between 4% and 13% of patients who receive public sector mental health benefits have executed a PAD. Individual barriers to completing a PAD include difficulty understanding advance directives and challenges in completing them, such as the complexity of legal forms and challenges of obtaining witnesses and having documents notarized and appropriately filed [3]. There are also system-level barriers, such as lack of staff awareness or communication among staff across complex mental health systems, and lack of access to the documents during a crisis [3].

The goal of PADs is to provide patients with the opportunity for increased autonomy regarding their mental health care, and, ideally to increase collaboration and alliance between the patient and their physician [2]. Studies suggest that this is the case [2], and that PADs can increase treatment adherence after discharge [3,4], and lower the likelihood of coerced treatment [5]. Patients with PADs also report that their “need for mental health treatment had been met” [3].

However, these studies do not identify whether it was the process of discussing treatment options and creating a PAD or the use of the directive to make treatment decisions that most influenced these outcomes. For example, research on facilitated advance directives [3] did not identify whether it was the conversation necessary to complete a PAD that provided the most benefit, or the actual execution of the PAD. Further, it is unknown if the physician’s familiarity with a patient had any influence on outcomes. To best promote the goals of PADs, it would be valuable to know the relative contribution of (1) the process of creating a PAD through in-depth conversation and consideration of treatment options, (2) familiarity with the patient’s history, and (3) the use of a PAD in making actual treatment decisions for patients in crisis. Further research in this area seems warranted.

Studies have shown that facilitated PADs virtually always align with standards of care. For patients deemed to pose a danger to themselves or others, a PAD does not “supersede the legal authority established by state civil commitment statutes or the authority of the court” [2].

ETHICALLY SALIENT DIFFERENCES BETWEEN PSYCHIATRIC & MEDICAL ADVANCE DIRECTIVES

Both psychiatric and medical advance directives promote patient autonomy by allowing an individual with decision-making capacity to make known their preferences for future care in the event they become unable to participate in care decisions. However, medical and psychiatric advance directives differ in ethically significant ways.

Medical advance directives (MADs) govern decisions about life-sustaining interventions in contexts of terminal illness or catastrophic injury. To this extent, they address the timing and circumstances of a foreseeable death. PADs, however, govern treatment decisions during episodes of care in relapsing mental health conditions [6], the expected outcome of which is a return to baseline behavior, baseline function, or some other stable end point [6]. Importantly, patients who execute PADs have firsthand experience and knowledge of interventions that most patients who execute MADs do not. They have been able to form clear preferences that can be expressed in a PAD.

The patient’s ability to communicate also distinguishes MADs from psychiatric directives. In situations of terminal illness or catastrophic injury, patients often experience significant impairment or total loss of the ability to communicate [6]. If a patient with a MAD regains the ability to communicate, their stated wishes in the moment supersede the instructions in their advance directive. Interpreting a psychiatric patient’s coherently articulated wishes when they conflict with the instructions in a PAD is more challenging. Contemporaneously expressed wishes may reflect the patient’s relapsing mental illness, not the wishes expressed when the patient was not in crisis and do not automatically supersede the directive. In such situations, physicians must evaluate the patient’s immediate versus overall best interest and the consequences of overriding the PAD, including the effect any decision may have on trust in the patient-physician relationship.

DECISION-MAKING CAPACITY, AUTONOMY & FUTURE SELVES

Concepts of decision-making capacity and autonomy are central to the process of advance care planning and the use of both medical and psychiatric advance directives. But while they pose fundamentally similar challenges in both contexts, there are important nuances.

The process of advance care planning and use of advance directives is intended to guide treatment for patients should they become unable to make care decisions themselves. To participate meaningfully in the process of advance care planning and to execute a valid advance directive, patients must have decision-making capacity. That is, the patient must be able to understand and reason about future treatment choices and to articulate preferences for future care in light of their values, goals, and life experiences, including prior health care experiences.

Decision-making capacity also plays a role in determining when an advance directive will govern treatment decisions. Directives take effect when the patient has lost decision-making capacity and is not able to make or express contemporaneous choices among treatment options. Decision-making capacity in the moment is assessed relative to the specific decision to be made—a patient may have capacity to make some decisions, but not others. Moreover, capacity can fluctuate over the course of an illness or episode of care. While for patients, for example, those who have experienced extensive brain damage for whom there is no reasonable expectation of regaining cognitive function, physicians can make a global assessment; for others, capacity must be assessed over time and in relation to the decision at hand.

For patients with mental health conditions, the question of capacity can be particularly challenging, since mental function itself is affected by psychiatric illness [6]. The baseline function of a psychiatric patient may or may not be similar to that of a patient who does not have a psychiatric illness. In addition, mental disorders often include impairment of certain isolated functions, while other functions are unaffected [6]. Assessing change in a psychiatric patient's decision-making capacity relative to their individual baseline may be difficult, especially when patient and physician have no previous relationship. Loss of capacity for a patient with a psychiatric illness may be both “less obvious and more likely to reflect a socially constructed understanding of good decision making” [6].

In cases where decision-making capacity may fluctuate, such as bipolar disorder—whether “objectively” or merely from the perspective of the patient—there is evidence that patients support advance directives out of fear that in the future they may be in mental states where their thinking is distorted [7]. Offering such patients this option may ameliorate those fears somewhat, though this does give privileged control to the prior self that is making the decision at a given time.

Advance directives are intended to be binding when a patient loses decision-making capacity. The use of such directives as a tool to promote patient autonomy presumes that a patient's future incapacitated self will agree with the choices made by their earlier self. Unfortunately, we know that people do not always accurately predict their future reactions in a given situation. Dresser notes that, “a growing body of research reveals that these sorts of mistakes occur whenever people make choices about what would be good and bad for them in the future. Empirical data suggest that people generally underestimate the extent to which their preferences and values will change in the future. People also tend to predict that ‘bad events will be worse than they turn out to be’” [8], and that preferences may change over time. Patients may turn out to be more accepting of outcomes they previously shunned or find burdens more onerous or insupportable than they once anticipated.

By definition, advance directives favor the autonomy of a prior self over the current self. However, whether the prior expression of a patient's autonomy should always prevail remains a debated question. As Dresser observes, such “precedent autonomy” is an important, but not the *only* consideration in making treatment choices for patients who cannot participate in the process themselves [9].

The question may become particularly acute in the context of psychiatric illness. To what extent is the self who is suffering from a psychiatric relapse or crisis truly autonomous, even when the individual communicates coherently? There can be considerable benefit in adhering to preferences stated by the mentally stable self, which were intended precisely to address circumstances of relapse or crisis. By executing a PAD, the patient obligates themselves to what proponents have called a Ulysses contract: “just as [Ulysses] instructed his crew to bind him to the mast before they sailed past the irresistible Sirens and to ignore his requests for release, such patients should be able to contract with their physicians to disregard certain specified instructions they might issue during relapse (such as refusing needed treatment) for a limited period of time” [10].

RELEVANT AMA POLICY

Currently, the AMA does not have specific policy regarding psychiatric advance directives. However, AMA policy is strongly supportive of the philosophy, goals, and use of advance directives in general. Guidance in the *AMA Code of*

Medical Ethics in Opinions 5.1, [“Advance Care Planning,”](#) particularly underscores the ethical values of patient autonomy and self-determination and sets out physicians’ responsibilities to encourage and assist advance care planning. Opinion 5.2, [“Advance Directives,”](#) addresses the conditions for sound application of advance directives in making clinical decisions for patients who lack capacity.

House policies similarly support advance directives and encourage their use:

- H-140.845, [“Encouraging the Use of Advance Directives and Health Care Powers of Attorney”](#)
- H-85.956, [“Educating Physicians About Advance Care Planning”](#)
- H-85.957, [“Encouraging Standardized Advance Directives Forms within States”](#)
- H-85.952, [“Advance Directives During Pregnancy”](#)

STATE LAW

Nearly every state in the U.S. allows for PAD in some form [2], either directly in statutes that specifically permit PADs, or indirectly in advance directive laws that allow directives that address mental health care [11-21].

Particularly noteworthy is Virginia, which is the “first state to purposefully commit itself to systematically incorporating psychiatric advance directives into routine mental health care practice” [1]. Virginia’s “Health Care Decisions Act” authorizes advance directives for all medical decisions and allows patients to give instructions on “any aspect” of their psychiatric care. A PAD takes effect under the law when the treating physician and a second independent physician or clinical psychologist determine that the patient has lost decision-making capacity [22-24]. Nevada and New Hampshire, in contrast, do not permit free-standing directives explicitly for psychiatric care, but do allow patients to appoint a Durable Power of Attorney for Health Care and encourage patients to convey their specific wishes regarding psychiatric treatment to their health care agent [25,26].

A majority of state statutes allow mental health providers “to petition a court to have a PAD overridden when the patient’s PAD runs contrary to the patient’s best interest” [2]. However, in *Hargrave v. Vermont* the U.S. 2nd Circuit Court of Appeals found “legal precedent precluding the ability to override a patient’s expressed preferences in a PAD” [2]. While this precedent is not binding nationally, it holds persuasive influence and “could be cited in a challenge to any PAD statutes that allow for overriding stated preferences that are not consistent with standard of care or safety needs” [2].

CONCLUSION

Advance care planning and the use of advance directives can help support shared decision making and promote patient autonomy and interests. In the context of psychiatric care, whether patients benefit more from engaging with physicians in the planning process or from the implementation of directives in episodes of relapse or crisis offers opportunity for further study. The deeper question under what conditions the “precedent autonomy” reflected in a PAD should prevail over the patient’s contemporaneously expressed wishes remains a matter of philosophical debate.

RECOMMENDATION

Your Board of Trustees recommends that the following be adopted in lieu of Resolution 1-I-19 and the remainder of this report be filed:

That our AMA:

1. Recognizes the potential for advance care planning to promote the autonomy of patients with mental illness; and
2. Urges the mental health community to continue to study the role of advance care planning in therapeutic relationships and the use of psychiatric advance directives to promote the interests and well-being of patients and support efforts to increase awareness and appropriate utilization of psychiatric advance directives.

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14. AMENDMENT TO TRUTH AND TRANSPARENCY IN PREGNANCY COUNSELING CENTERS, POLICY H-420.954 (RESOLUTION 8-N-21)

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

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy H-420.954

Resolution 8-N-21, “Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954,” submitted by the Medical Student Section, calls on our AMA to amend existing policy “to further strengthen our AMA policy against the dissemination of purposely incomplete or deceptive information intended to mislead patients and the utilization of state and federal funds for potentially biased services provided by pregnancy counseling centers,” as follows:

H-420.954, Truth and Transparency in Pregnancy Counseling Centers

1. Our AMA ~~supports~~ advocates that any entity offering crisis pregnancy services disclose information on site, in its advertising; and before any services are provided concerning medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it does and does not provides, as well as fully disclose any financial, political, or religious associations which such entities may have;
2. Our AMA discourages the use of marketing, counseling, or coercion (by physical, emotional, or financial means) by any agency offering crisis pregnancy services that aim to discourage or interfere with a pregnant woman's pursuit of any medical services for the care of her unplanned pregnancy;
3. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws, and additionally disclose their level of compliance to such requirements and laws to patients receiving services;
4. Our AMA opposes the utilization of state and federal funding to finance such entities offering crisis pregnancy services, which do not provide statistically validated evidence-based medical information and care to pregnant women.

Testimony at the November 2021 Special Meeting of the House of Delegates generally supported the intent of the resolution, noting the predatory actions taken by many nonclinical pregnancy counseling centers. However, testimony also expressed concern with the specific amendments as proposed, including concern about the feasibility of monitoring or enforcing compliance with disclosure requirements.

BACKGROUND

On the best current estimate, there are nearly 5,000 pregnancy counseling centers (also known as “crisis pregnancy centers” and “limited services pregnancy centers”) in the U.S. that provide health-related services and counseling to women who are or believe they may be pregnant, with the goal of dissuading women from seeking or receiving abortion [1,2]. Opposition to abortion is legally permitted and ethically recognized, and such centers do offer benefit to their clients, including social and other support, for those who choose to continue their pregnancies. Because pregnancy counseling centers do not charge for their services, they may be particularly attractive to women who otherwise have limited or no access to clinical care.

However, centers are also known to mislead prospective clients, implying that they offer or provide referral for abortion or contraceptive services [3], and to engage in practices that inhibit timely decision making for pregnant women who are seeking abortion [1,2,3]. Although increasingly such centers employ licensed medical personnel and are recognized as licensed medical facilities [1], the majority are not subject to regulatory oversight [3].

Since the 1980s, there have been multiple legal efforts to curb centers' false or misleading advertising of their services and their misleading presentation of medical information [1,2,3]. Most recently Connecticut enacted [Public Act No. 21-17](#), “Act Concerning Deceptive Advertising Practices of Limited Services Pregnancy Centers,” which went into effect in July 2021. The act prohibits centers from making “any statement concerning any pregnancy-related service or the provision of any pregnancy-related service that is deceptive, whether by statement or omission” that the center “knows or reasonably should know to be deceptive.” Whether the law will survive possible legal challenge or prove effective remains to be seen.

California's Reproductive FACT (Freedom, Accountability, Comprehensive Care, and Transparency) Act, passed in 2015, called for clinics to provide specific disclosures regarding services. Medically licensed centers would have been required to post specific notice that public programs “provide immediate free or low-cost access to comprehensive family planning services ... prenatal care, and abortion for eligible women,” with the telephone number for county social services. Unlicensed centers would have been required to post notice that the center was “not licensed as a medical facility by the State of California and has no licensed medical provider who provides or directly supervises the provision of services” [1]. The act was immediately challenged on grounds of free speech and free exercise of religion but was upheld by district courts and the U.S. Court of Appeals for the Ninth Circuit. However, in June 2018 the U.S. Supreme Court reversed the Ninth Circuit and “remanded the case for further proceedings consistent with the conclusion that the free speech challenge was likely to succeed” [1].

POLICIES OF PROFESSIONAL MEDICAL ORGANIZATIONS

In 2019, the Society for Adolescent Health and Medicine (SAHM) and the North American Society for Pediatric and Adolescent Gynecology (NASPAG) published a joint position statement opposing crisis pregnancy centers. The statement encourages government entities “to only support programs that provide medically accurate, unbiased, and complete health care information,” including information about FDA-approved contraceptives and “the full range of pregnancy options” [4]. The statement further urges regulatory and accrediting bodies to ensure that health care professionals and services provided at crisis pregnancy centers “adhere to established standards of care,” as well as discouraging school boards from “outsourcing sexuality education” to such centers and urging companies that own digital platforms and search engines to monitor how centers represent their services and taking steps to prevent misrepresentation [4].

The American College of Obstetricians and Gynecologists (ACOG) opposes legislative, financial, and other barriers that restrict access to abortion, including the “nonlegislative” barrier posed by crisis pregnancy centers [5]. ACOG has criticized crisis pregnancy centers for providing inaccurate medical information linking abortion with breast cancer, infertility, and mental health on Twitter (#FactsAreImportant, September 3, 2020).

AMENDING POLICY H-420.954

Given the failure of efforts to regulate crisis pregnancy centers, and the fact that the Supreme Court’s 2018 decision suggests notifications of the sort proposed by California would likely amount to “compelled speech impermissible under the First Amendment” [1], it is not clear that amending H-420.954 as Resolution 8-N-21 urges would materially strengthen policy or enhance AMA’s ability to oppose crisis pregnancy centers in further legal action. The more prescriptive the policy statement, the less room for action it may offer.

Nonetheless, it is not unreasonable to argue that any entity that represents itself as offering health-related services or counseling, including crisis pregnancy centers, should be expected to adhere to standards of truthfulness and transparency expected of licensed health care facilities and licensed personnel. Many policies of the House of Delegates touch on issues of truth in advertising analogous to those posed by crisis pregnancy centers. Most closely related is Policy [H-150.946](#), “Herbal Supplements,” which holds that “that the naming, packaging, and advertising of dietary supplement products be such that they cannot be confused with pharmaceutical products.”

Other policies similarly touch on the fundamental issue of truthful representation, including:

- [H-160.921](#), “Retail Clinics”
- [H-175.992](#), Deceptive Health Care Advertising
- [H-180.945](#), Health Plans’ Medical Advice
- [H-225.994](#), Hospital Advertising in Printed and Broadcast Media
- [H-270.982](#), Truth in Advertising Standards for Managed Health Care Plans
- [H-405.968](#), Clarification of the Term “Provider” in Advertising, Contracts, and other Communication
- [E-9.6.1](#), Advertising and Publicity
- [E-9.6.7](#), Direct-to-Consumer Advertising of Prescription Drugs and Medical Devices
- [E-9.6.8](#), Direct-to-Consumer Diagnostic Imaging Tests

Still further policies address truth and advertising with respect to nonclinical products, e.g.:

- [H-495.981](#), Light and Low-Tar Cigarettes
- [H-495.985](#), Smokeless Tobacco

AMA likewise has strong policy on the obligation to provide scientifically accurate information and support informed decision making, including:

- [E-8.12](#), Ethical Physician Conduct in the Media
- [H-140.989](#), Informed Consent and Decision-Making in Health Care
- [E-2.1.1](#), Informed Consent
- [E-2.1.3](#), Withholding Information from Patients

Taken together, existing AMA policies provide ample foundation to argue for oversight of crisis pregnancy centers. Moreover, the recent SAHM-NASPAG position statement discussed above offers more circumspect language than that proposed by Resolution 8-N-21. That is, to focus on what oversight bodies can and should do rather than dictate specific practice to crisis pregnancy centers.

RECOMMENDATION

For the reasons discussed above, your Board of Trustees recommends that Policy H-420.954 be amended by insertion and deletion to read as follows in lieu of Resolution 8-N-21 and that the remainder of this report be filed:

H-420.954, “Truth and Transparency in Pregnancy Counseling Centers”

1. It is AMA’s position that any entity that represents itself as offering health-related services should uphold the standards of truthfulness, transparency, and confidentiality that govern health care professionals.
2. Our AMA urges the development of effective oversight for entities offering pregnancy-related health services and counseling.
3. Our AMA supports advocates that any entity offering crisis pregnancy services ~~disclose information~~
 - a. truthfully describe the services they offer or for which they refer—including prenatal care, family planning, termination, or adoption services—in communications on site, and in its their advertising, and before any services are provided to an individual patient; and concerning medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it provides,
 - b. be transparent with respect to their funding and sponsorship relationships.
4. Our AMA advocates that any entity licensed to provide ~~providing~~ medical or health services to pregnant women ~~that markets medical or any clinical services abide by licensing requirements and have the~~
 - a. ensure that care is provided by appropriately qualified, licensed personnel; to do so and
 - b. abide by federal health information privacy laws.
5. Our AMA urges that public funding only support programs that provide complete, non-directive, medically accurate, health information to support patients’ informed, voluntary decisions.

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15. ADDRESSING PUBLIC HEALTH DISINFORMATION

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies H-460.978, D-440.914, and D-440.915

INTRODUCTION

At the November 2021 special meeting of the AMA House of Delegates, the House adopted Policy D-440.914, “Addressing Public Health Disinformation Disseminated by Health Professionals” which called on the AMA to study disinformation disseminated by health professionals and its impact on public health and present a comprehensive strategy to address this issue with a report back at the next meeting of the House of Delegates.

During the COVID-19 pandemic, the public health emergency was undoubtedly worsened and prolonged due to disinformation campaigns sowing distrust in vaccines, pharmaceutical interventions, and public health mitigation measures. Health professionals spreading disinformation lends credibility to specious claims.

For the purposes of this report, health professionals include, but are not limited to, those working in health care who maintain a professional license. Examples of licensed health care professionals include, but are not limited to: Doctor of Medicine or Doctor of Osteopathic Medicine, nurses, nurse practitioners, nurse-midwives, physician assistants, chiropractors, podiatrists, dentists, optometrists, pharmacists, clinical psychologists and clinical social workers. Health professionals may also include public health professionals, who may or may not be licensed health care professionals.

OVERVIEW OF DISINFORMATION

For the purposes of this report, the term “disinformation” is used to describe false or misleading information of which the author knows to be wrong and intends to cause harm.¹ Disinformation is often interchangeably used with “misinformation”, however a key distinction between the two is the intent of the author. Misinformation is spread unwittingly, whereas disinformation is intentionally disseminated to confuse, deceive, or otherwise manipulate the reader. Misinformation is outside of the scope of this report as is the spread of disinformation by non-health professionals.

Example of Disinformation Campaigns

During the COVID-19 pandemic, disinformation has been among the utmost concerns, leading some to describe a secondary “infodemic” wherein permanent harm may be done to the trust in institutions due to the sheer volume of disinformation spread in a rapidly changing and sensitive environment.^{2,3,4} Disinformation claims made by health professionals can be directly linked to topics such as the promotion of unproven COVID-19 treatments, false claims of vaccine side effects, and public health guidance that is not evidence-based.^{5,6,7,8} Health professionals have been involved in disseminating health-related disinformation, long before the COVID-19 pandemic, this includes promoting vaccine skepticism^{9,10} and dangerous anti-cancer treatments.¹¹

An illustrative case study for how health professionals have spread disinformation is around vaccinations. Vaccine hesitancy dates back to the 1700s and the practice of inoculation, particularly when vaccination was accompanied by government action.¹² These debates have centered around bodily autonomy and the role of the government in mandating immunizations. While the merits of these questions are debated by policymakers, the arguments for vaccination must be based in science. However, historically, this has not been the case, with numerous instances of health professionals engaging in disinformation tactics to achieve their desired political outcomes.

For example, a 1974 study falsely claimed that 36 children developed neurological side effects within 24 hours after receiving a routine diphtheria, tetanus, and pertussis (DTaP) vaccination.¹³ Despite efforts by public health officials to combat the false information, the bell had already been rung, and many countries saw sharp declines in DTaP vaccine uptake, and some halted vaccination campaigns altogether.

Then, in 1998, a manuscript was published in *The Lancet* using fabricated data linking the measles, mumps, and rubella (MMR) vaccine to autism.¹⁴ While the physician responsible for the fraudulent research ultimately had their medical license revoked and the paper was retracted, the impact it had on vaccine discourse and uptake was profound. One study found that this single manuscript falsely linking MMR vaccines to autism resulted in an immediate increase of about 70 MMR injury claims per month to the Vaccine Adverse Events Reporting System (VAERS), and a 10 percent increase in negative media coverage of vaccines.¹⁵ The false connection between autism and vaccines has persisted and is often part of the core messaging in anti-vaccination campaigns.^{16,17,18}

The troubling impact of health professionals creating and spreading vaccine disinformation in the context of the COVID-19 pandemic is discussed later within this report.

PROFESSIONAL RESPONSIBILITY OF HEALTH PROFESSIONALS

Ethical Obligations

Health professional associations have outlined standards of conduct that define ethical behavior. The AMA Principles of Medical Ethics state that a physician should continue to apply scientific knowledge and recognize the responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.¹⁹ Given the growing reliance and presence of health information on the internet, the AMA has also published *Code of Medical Ethics* Opinion 8.12, “Ethical Physician Conduct in the Media.” This opinion outlines that although physicians who participate in the media can offer effective and accessible medical perspectives, they have an ethical obligation to consider how their conduct can affect their medical colleagues, other health care professionals, as well as institutions with which they are affiliated. Most importantly, it states that physicians will be taken as authorities when they engage with the media and therefore should ensure that the medical information, they provide is accurate and based on valid scientific evidence. Further, *Code of Medical Ethics* Opinion 10.1 states that even when a physician is in a role that does not involve directly providing care for patients in clinical settings, “physicians are seen by patients and the public, as well as their colleagues and coworkers as professionals who have committed themselves to the values and norms of medicine.”

Finally, it has been suggested that health professionals also have an ethical obligation to correct false or misleading health information, share truthful health information, and direct people to reliable sources of health information within their communities and spheres of influence.²⁰ In the modern information age, where the unconstrained and largely unregulated proliferation of false health information is enabled by the internet, health professionals have an ethical duty to actively participate in conversations about health and help correct false or harmful information.

Other health professionals have similar ethical standards. For example, the Ohio State Chiropractic Association Members’ Code of Ethics states that chiropractors should act as members of a profession dedicated to the promotion of health, the prevention of illness and the alleviation of suffering. This includes guidance that chiropractors should exercise care when advertising to ensure the information is accurate, truthful, not misleading, false or deceptive, and is accurate in representing the chiropractor’s professional status and area of special competence.²¹

Recently, the Boards of the American Pharmacists Association and the National Alliance of State Pharmacy Associations approved principles that are essential to fulfill a pharmacist’s professional responsibilities. This includes using evidence-based guidelines when prescribing medications and emphasizing that pharmacists play an active role in reinforcing consistent and reliable public health messages while helping to provide accurate health-related information to patients in an era of misinformation.²²

Trust in Health Professionals

It is critical to understand the role that health professionals acting in good faith play in the health information ecosystem. Multiple surveys have shown that health professionals are the most trusted sources of health information, particularly when compared to government institutions.^{23,24} Data suggests that nine-in-ten U.S. adults (89 percent) have either a great deal or a fair amount of confidence in medical scientists to act in the public interest.²⁵ In 2018, the top three professions in the Gallup poll for honesty and ethics were nurses, medical doctors, and pharmacists.²⁶ Nurses were rated the highest, where 84 percent of people rated nurses’ honesty and ethical standards as high or very high. Studies find that trust in health professionals lead to increased vaccination rates, whereas mistrust of health professionals was found to be a common theme amongst parents who lacked confidence in vaccines.^{27,28} While trust

is a complex, multi-faceted concept, the professional nature, high degree of training, and ability to connect to an individual are important factors for health professionals gaining and maintaining trust.

It should also be noted that health professionals are more than just experts in the public square. Many health professionals engage with the public as educators, advocates, entertainers and more. It is critical that future measures against disinformation preserve the totality of roles that health professionals may hold. Similarly, it must be respectful of the totality of thought that may exist within the profession and hold spaces for professional discourse that may challenge traditional thinking. While heterodoxy may undermine trust and allow for the spread of disinformation, it is often a necessary step before learning from historical mistakes. Actions taken that strengthen trust in health professionals will be undercut if they result in an overall retraction of health professionals from the public square, which may result in less credible voices filling the void. Policies and practices that promote the perception of inaction or indifference corrode trust similarly to bad behavior.²⁹

IMPACT OF DISINFORMATION

Impact on Patients and the Public

The prevalence disinformation about COVID-19 has been fueled by social media. More than three quarters of U.S. adults either believe or are not sure about at least one of eight false statements about the COVID-19 pandemic or COVID-19 vaccines.³⁰ The same study found one-third believe or are unsure whether deaths due to the COVID-19 vaccine are being intentionally hidden by the government, and about three in ten each believe or are unsure whether COVID-19 vaccines have been shown to cause infertility. In addition, between a fifth and a quarter of the public surveyed believe or are unsure whether the vaccines can cause COVID-19 (25 percent), contain a microchip (24 percent), or can change DNA (21 percent).

The spread of disinformation regarding unproven medications to treat COVID-19 also led to direct patient harm. In the first eight months of 2021, the National Poison Data System reported an increase of over 150 percent in the number of calls made to poison control centers, with states such as Mississippi issuing alerts about the surge of calls from individuals overdosing on ivermectin.³¹

Impact on Minoritized Communities

When assessing the impact of disinformation spread by health professionals, it is also important to consider the disproportionate impact that it may have on different communities. Many of the most common COVID-19 disinformation campaigns require the reader to distrust institutions such as the federal government or the pharmaceutical industry.³² For minoritized communities that have historically been failed by these same institutions, the initial belief that those in power may be untrustworthy is not as large of a logical leap.^{33,34} These beliefs may be intergenerational and are reinforced by the multitude of injustices faced by minoritized communities in health care.^{35,36} As such, any strategy for combating disinformation which does not center itself in restorative justice is unlikely to strengthen trust in any meaningful and lasting way.

Impact on the Health Profession

Disinformation spread by health professionals can have both direct and indirect impacts on health care and public health. In the above example of vaccine disinformation, health professionals spreading falsified research resulted in decreases in vaccine confidence and uptake resulting in outbreaks of preventable disease.³⁷ But it also corroded trust in health professionals which gave way to targeted harassment campaigns of those following the science.³⁸

More difficult to measure are the indirect impacts. Studies have shown that an individual's trust in their health professional directly correlates to more positive health outcomes, due to factors such as more candid responses to personal questions and better adherence to treatment plans.³⁹ But when health professionals engage in actively spreading disinformation, there may be an overall corrosion of trust in health professionals.

Economic Impact

The spread of disinformation has had large economic impacts as seen during recent measles outbreaks and the COVID-19 pandemic. Studies show that the cost of a measles outbreak ranges from \$9,862 to \$1,063,936, with a median cost

per case of \$32,805.⁴⁰ In 2013, the New York City Department of Health and Mental Hygiene’s response to a measles outbreak cost an estimated \$395,000, which supported more than 10,000 hours of staff time along with other costs.⁴¹ In 2019, Clark County Public Health, in Washington state, spent nearly \$865,000 responding to a measles outbreak.⁴²

Data suggests that non-vaccination during the COVID-19 pandemic has caused harm of \$1 billion per day and misinformation and disinformation has caused between 5 percent and 30 percent of this harm.⁴⁶ Further, misinformation and disinformation has caused between \$50 and \$300 million worth of total harm every day since May 2021.⁴⁶ These estimates demonstrate how mis- and disinformation contributes to the spread of disease and the effect both can have on the public health system. Finally, studies examining causality between mis- and disinformation and nonvaccination are limited. One estimate suggests that of the 43 million people in the U.S. who have chosen nonvaccination against COVID-19, 2 million to 12 million were unvaccinated because of misinformation or disinformation.⁴³ More research is needed to better understand the impact of disinformation on vaccination rates. Although the focus of this report is solely on disinformation, the currently available data on the economic impact does not distinguish between the cost of misinformation and disinformation.

HOW DISINFORMATION IS SPREAD

Social Media

It is impossible to discuss the spread of disinformation in modern times without mentioning social media. While disinformation existed long before the internet and social media became commonplace, it has acted as a multiplier of disinformation spread and a lightning rod for criticism. Platforms such as Twitter, Facebook, YouTube, Instagram and TikTok have all faced recent criticism over their handling of medical disinformation on their platforms.^{44,45,46} Even Doximity, a platform targeted to credentialed physicians that does not allow anonymous users, has not been immune to concerns over disinformation during the COVID-19 pandemic.⁴⁷

In the current environment, individuals often value convenience more than trust when making decisions about their health. For example, when individuals were surveyed about consumer behaviors regarding unregulated online pharmacies, approximately 1 in 4 Americans indicated that they would accept higher risk from purchasing at an illegal, unregulated online pharmacy if it was more convenient.⁴⁸ Alarmingly, prioritizing convenience over accuracy holds true for health professionals. Paradoxically, one survey found that only 2.2 percent of health professionals found social media to be a trustworthy source for health information, but 18.2 percent of the same cohort indicated that they get health information from it.⁴⁹

Social media is a high-risk platform for receiving health information due to the main ways in which users are shown content: algorithmic recommendations. Most social media platforms utilize algorithms to promote content to the consumer in efforts to drive increased interaction with the site. For example, YouTube estimates that approximately 70 percent of all videos watched on their platform are through recommendations.⁵⁰ Researchers of social media platforms have shown that algorithms tend to prioritize metrics such as watch time, likes and comments, all of which favors content that elicits an emotional response like anger and reinforce previously held beliefs rather than promote factual accuracy.⁵¹ For example, internal documents leaked from Facebook indicated that their algorithm prioritized the “angry face” emoji reaction higher than the “thumbs up” (“like”) reaction even when their own internal data suggested emotion-provoking content was more likely to contain misinformation.⁵²

Amid intense criticism during the COVID-19 pandemic, some social media platforms began adjusting their algorithms to de-incentivize disinformation or to automatically include cautionary statements on high-risk content and provide links to trusted source such as the Centers for Disease Control and Prevention (CDC) or World Health Organization.^{53,54,55, 56} Many of these policies are too new to fully appreciate their impact, but preliminary studies suggest that tweaks to the YouTube algorithm dropped views on videos supporting conspiracy theories by up to 70 percent.⁵⁷ It should be noted, however, that this effect may not be durable – that is, content creators learned how to evade automated detection over time and the initial loss of views was partially recovered.

Social media companies at the end of the day are privately owned, profit-driven businesses. The algorithms were designed to maximize advertising revenue and user retention. Broad, sudden changes in policy that target disinformation may lead to an increase in competitors that market themselves as bastions of free speech in the marketplace of ideas.

The ideal role of health professionals in the social media landscape is unlikely to be one solely relying on reactive fact-checking. First, reactive fact-checking is unsustainable as it requires significantly more effort to do the research and provide refutations than it does to create the disinformation in the first place. Colloquially, this asymmetry of effort is referred to as “Brandolini’s law”.⁵⁸ Second, by the time disinformation reaches a qualified health professional who may be able to fact-check it, it is likely to have already had significant spread. Finally, reactive fact-checking can result in the “Backfire effect,” in which some individuals are so invested in maintaining their viewpoint that external attempts to correct disinformation will instead make the reader *more* inclined to believe the disinformation.⁵⁹

As such, combating disinformation spread by health professionals, particularly over social media, will require a three-pronged approach: deprioritizing disinformation in social media algorithms, affirming and empowering the role of reactive fact-checking, and addressing any underlying incentive structure for health professionals spreading health-related disinformation.

Traditional Media and Paywalls

When assessing the spread of health-related disinformation, it is important to understand where the underlying data come from. Disinformation does not necessarily imply that claims are entirely fabricated, but instead may rely on the distortion or intentional misrepresentation of otherwise valid figures. In the medical research ecosystem, this is commonly seen with the misrepresentation of *in vitro* results as holding significant value *in vivo*.

While the general public may not appreciate the nuance in medical research literature, health professionals should, and risk spreading disinformation when they sensationalize research claims. This is amplified further when health professionals are leaned on for their expertise in translating complex topics by media organizations. Like social media companies discussed above, traditional or online media companies often have the same financial motivations and accompanying tensions –sensationalized stories result in increased readership while well-sourced, measured journalism is expensive and time-consuming to create.^{60,61} Unfortunately this results in trustworthy news increasingly being locked behind paywalls, with approximately 68 percent of U.S. news entities limiting free access to their content in 2019, an increase of 13 percent over 2 years.⁶² As outlined above, this creates an ecosystem for low-quality, sensationalist websites without journalistic integrity to thrive due to the desire to value ease of access and convenience over perceived quality.

During the COVID-19 pandemic, some publications switched to a model in which public health information was published for free. While this led to an increase in available high-quality resources, it also required individuals to modify the routines they had built up over years of seeking out free information, which may have limited impact.

Peer-Reviewed Journals and Preprints

Academic research faces a similar problem as social media and traditional print journalism: convenient access trumps the perception of quality. During the COVID-19 pandemic, there has been an unprecedented surge in the number of academic articles published as “preprints,” in which research articles are disseminated prior to peer-review in an academic journal.⁶³

Under the traditional model, academic research is submitted to a journal, reviewed by an editor, and then sent to experts in the field for anonymized peer review. These peer reviewers will critically analyze the research for experimental structure and whether the conclusions offered are supported by the collected data. Peer review may result in the researchers being required to perform additional experiments to support their conclusions, or it may result in the research article being rejected outright from the journal. It serves as a critical check in the scientific process to enable high quality, trusted research, but it is often criticized as being unnecessarily slow and needlessly antagonistic.⁶⁴

A preprint circumvents the peer review process by not being published in an academic journal and instead being uploaded to a freely accessible database. This is not a new phenomenon, but the push towards open access research and the appetite for up-to-date information during the COVID-19 public health emergency resulted in a surge in preprints, particularly in the life sciences. Preprints have been praised as a way of elevating younger researchers, reducing predatory publishing in which researchers may pay fees to less credible journals for favorable peer reviews, and generally being more accepting of negative findings.⁶⁵

These benefits, however, require skipping peer review, meaning that the results may be less trustworthy, particularly for non-expert audiences that may not be able to critically evaluate experimental structures for things like adequate control groups. Depending on the author and the database, preprints may be type-set to imitate the look of common academic journals, and most are then assigned a Digital Object Identifier (DOI), which allows them to be tracked through academic databases such as Crossref and Datacite. The name preprint suggests that the article is in the process of undergoing peer review, but approximately 30 percent of life sciences preprints are never published.⁶⁶

Preprints and paywalls represent a clear tension in solving the disinformation crisis. Access to an individual, high-quality life sciences journal can cost thousands of dollars, and research is spread across multiple journals in any given field. Yet free, easy-to-access preprints will often be the only resource accessed by both health professionals and the public seeking to understand complex issues even if they may be rife with errors, conflicts of interest or unsupported conclusions.

Incentives for Spreading Disinformation

Previous sections outlined why there is an audience for health disinformation content, but spreading disinformation requires there to be a party engaging with malice. For health professionals spreading health-related disinformation, this seems paradoxical. Most, if not all, health professionals take a professional oath to do no harm, and a misinformed public would seemingly make that job harder.

At first glance, health-related disinformation appears to be a highly fractured entity, as it is spread through a huge number of social media accounts and micro-targeted blog sites. However, deeper analysis reveals that the source of the various content is heavily centralized. For example, the Center for Countering Digital Hate (CCDH) released a report in which they analyzed one month of anti-vaccine posts on social media, and found that nearly two-thirds of the claims (over 812,000 individual posts) could be traced back to twelve individuals, nicknamed the “Disinformation Dozen.”⁶⁷ This is in general agreement with the public statements of social media platforms such as Doximity, which claim that less than one-tenth of one percent of their active users have been found to spread disinformation.⁶⁸

Of the dozen individuals identified by CCDH, six have at one point held a license from a professional medical accrediting body, and at least two others represent themselves as health experts, albeit not from a credentialed profession. While it is impossible to infer intent from their public statements, spreading disinformation is a lucrative business for the Disinformation Dozen. The most common monetization model for health professionals spreading disinformation resembles the “influencer economy” born out of social media: monetizing their video channels and social media followings through advertisements, selling books containing medical disinformation, running subscription-based services which procure and disseminate disinformation, multi-level marketing schemes, public speaking tours, and paid media appearances.

Beyond the indirect routes of monetization, there are also instances of credentialed health professionals using disinformation to drive patients towards their medical practices. For example, one group currently under investigation by the House Select Subcommittee on the Coronavirus Crisis is believed to be charging upwards of \$700 per patient for telehealth consults which were advertised to be with health professionals more likely to prescribe controversial, medications not authorized or approved to prevent or treat COVID-19.⁶⁹ The group is estimated to have generated more than \$6.7 million in a 3-month period in 2021.

As such, any strategy to combat health professionals spreading disinformation must be two-fold: it must address their ability to find an audience, and it must address their ability to monetize an audience they do find.

AUTHORITY OF LICENSING AND CREDENTIALING BOARDS

Authority of Licensing Boards

Health professional boards exercise two main regulatory functions: licensure and discipline.⁷⁰ Licensure requires a demonstration of educational attainment and knowledge as evidence of competence at the time when health professionals begin practicing. Discipline, in contrast, oversees ongoing practice in a state. Health professionals can be disciplined for numerous misbehaviors, from business offenses to problems in the quality of care. Disciplinary actions range in severity from non-public warning letters, to public reprimand, to suspension or revocation of the license to practice. Disciplinary action is intended to protect the public directly by removing problematic health

professionals from practice, restricting their scope of practice, or improving their practice. Various state practice acts establish the boards' mission, structure and power, and the administrative procedure acts govern many health professional board processes, especially for promulgating regulations and holding hearings. Legislation also provides boards with their budgets and staffing authority. The structure and authority of medical boards vary from state to state.^{71,72,73} Some boards are independent and maintain all licensing and disciplinary powers, while others are part of a larger umbrella agency, such as a state department of health, exercising varied levels of responsibilities or functioning in an advisory capacity.^{74,75} Despite the varying scope and authority of boards, many health professional boards state that the use of a false, fraudulent, or deceptive statements in any connection with their practice, is ground for discipline.

Limitations to Board Authority

Unfortunately, boards face various impediments to their disciplinary powers. These include low funding and staffing, insufficient legal framework (i.e., too little statutory priority for public protection, no explicit quality ground for discipline, high legal standards of proof),⁷⁶ high costs of investigation and formal legal process, differing authority by state, and fear of litigation by aggrieved health professionals. Medical boards have faced some criticism. Some have argued that state medical boards have significant discretion over the investigative and disciplinary process in responding to complaints. However, they have no proactive capacity to monitor physicians outside of formal and cumbersome complaint processes, and during the investigative period, physicians under scrutiny are free to continue to spread disinformation and abuse their medical credentials without restraint.⁷⁷

First Amendment Considerations

The Federation of State Medical Boards (FSMB) has warned physicians that spreading disinformation about the COVID-19 vaccine could lead to the suspension or revocation of their medical license.⁷⁸ However, licensing boards are state actors and are subject to the First Amendment and are therefore limited in their ability to penalize health professionals based on the content of their speech. The First Amendment's protection of freedom of speech applies to all branches of government, including state licensing boards.⁷⁹ Based on existing Supreme Court precedent, courts are unlikely to look favorably on license revocations based on statements a health professional makes in a non-clinical context, even when those statements would constitute malpractice if they were made to a patient under care. This is because the board would have the burden of establishing not only that the interests it seeks to promote are compelling, but also that disciplinary action is the least restrictive means of achieving those goals.

In 2018 the Supreme Court elaborated on the First Amendment's application to laws restricting professional speech in *National Institute of Family and Life Advocates (NIFLA) v. Becerra*.⁸⁰ In that case, the Court struck down a California law that required "crisis pregnancy centers" that held licenses as health care facilities to notify women that the state provided free and low-cost pregnancy-related services, including abortions. The Supreme Court concluded that laws regulating professional speech are exempt from normal First Amendment standards. This suggested that the First Amendment places few, if any, restrictions on regulations of professional conduct.

This case has important implications for the scope of licensing boards' disciplinary authority. It implies that boards may have considerable discretion when disciplining health professionals for statements made in connection with medical procedures, because these actions would constitute the regulation of professional conduct. However, because a health professionals' statements on platforms such as social media are unconnected with any medical procedure, disciplinary actions based on those statements would be subject to normal First Amendment standards.

ACTIONS TAKEN BY HEALTH PROFESSIONAL BOARDS

Federation of State Medical Boards

The FSMB released a statement in response to a dramatic increase in the dissemination of COVID-19 vaccine misinformation and disinformation by physicians and other health care professionals on social media platforms, online, and in media. FSMB noted that the spread of mis- and disinformation is grounds for disciplinary action by state medical boards, that could result in suspension or revocation of their medical license.⁸³ Since the release of that statement at least 15 boards have published statements about licensees spreading false or misleading information, and at least 12 boards have taken disciplinary action against a licensee for spreading false or misleading information.⁸¹ The FSMB also released data from their 2021 annual survey which documented how medical boards are being

impacted by, and addressing, physicians and other health care professionals who spread false or misleading information about COVID-19. The survey found that 67 percent of state medical boards have experienced an increase in complaints related to licensee dissemination of false or misleading information, 26 percent have made or published statements about the dissemination of false or misleading information, and 21 percent have taken a disciplinary action against a licensee disseminating false or misleading information.⁸³

American Board of Medical Specialties

In 2021, the American Board of Medical Specialties (ABMS) released a statement stating that the spread of misinformation is harmful to public health, is unethical and unprofessional, and may threaten certification by an ABMS Member Board.⁸² Further, the American Board of Emergency Medicine⁸³, the American Board of Pathology⁸⁴ and a joint statement by the American Boards of Family Medicine, Internal Medicine and Pediatrics⁸⁵ have stated that health professionals who are certified by specialty boards and spread disinformation place their certifications at risk.

National Council of State Boards of Nursing

The National Council of State Boards of Nursing alongside multiple nursing organizations has also released a policy statement noting that the dissemination disinformation pertaining to COVID-19, vaccines, and associated treatments through verbal or written methods including social media may be disciplined by nursing boards and may place their license in jeopardy.⁸⁶

Pharmacy Boards

The American Pharmacists Association as well as various state boards have noted that inappropriately prescribing or dispensing medications that are not approved to prevent or treat COVID-19 could be considered unethical and unprofessional conduct and may violate board rules.^{87,88,89,90}

LEGISLATIVE EFFORTS SURROUNDING DISINFORMATION

Federal Efforts

Various federal efforts have been taken to address disinformation. For example, the CDC has published strategies for communicating accurate information about COVID-19 vaccines, responding to gaps in information, and confronting misinformation with evidence-based messaging from credible sources.⁹¹ The Surgeon General of the United States also published a report on strategies to help slow the spread of health misinformation during the COVID-19 pandemic and beyond. This includes strategies that major players can take including the government, health organizations, and individuals to address misinformation.⁹² Building upon this report, the Surgeon General is now collecting data from technology companies and personal experiences about misinformation during the COVID-19 pandemic.⁹³ Further, Senator Chris Murphy (D-Conn.) and Senator Ben Ray Lujan (D-N.M.) will introduce a bill promote public education on health care through a new committee in HHS. The Promoting Public Health Information Act will create the Public Health Information and Communications Advisory Committee, a group within HHS specializing in public health, medicine, communications and national security.⁹⁴

State Efforts

Given the growing impact of disinformation on the COVID-19 pandemic, state legislators have introduced bills to combat disinformation. For example, California's AB 2098 (2022), would codify that licensed physicians disseminating or promoting misinformation or disinformation related to COVID-19 constitutes unprofessional conduct that should result in disciplinary actions by the Medical Board of California or the Osteopathic Medical Board of California. However, these efforts by states have been met with great resistance. For example, Tennessee's medical licensing board voted to remove a policy opposing coronavirus misinformation from its website.⁹⁵ At the time of writing, 14 states have proposed legislation to weaken medical regulatory boards authority and their ability to discipline doctors who spread false information or treat patients based on it.⁹⁶ In response, the FSMB has released a statement in opposition to a growing legislative trend aimed at limiting state medical boards' ability to investigate complaints of patient harm.⁹⁷

AMA POLICY AND ACTIONS TO ADDRESS DISINFORMATION

Existing AMA Policy

AMA Policy D-440.914, “Addressing Public Health Disinformation Disseminated by Health Professionals,” calls on the AMA to collaborate with relevant health professional societies and other stakeholders: (a) on efforts to combat public health disinformation disseminated by health professionals in all forms of media and (b) to address disinformation that undermines public health initiatives; and (2) study disinformation disseminated by health professionals and its impact on public health and present a comprehensive strategy to address this issue. Existing Policy D-440.915, “Medical and Public Health Misinformation in the Age of Social Media,” encourages social media companies to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; (2) encourages social media companies to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms. The policy further calls on the AMA to continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts and work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.

Policy H-460.978, “Communication Among the Research Community, the Media and the Public,” calls for increased cooperation between the scientific community and the media to improve the reporting of biomedical research findings and to enhance the quality of health care information that is disseminated to the public. The policy notes that both scientists and journalists should communicate biomedical research findings accurately and in an appropriate context. Journalists should include information on the limitations of research and should be cognizant of the emotional content of the health news they report. Furthermore, academic institutions, private industry, individual scientists, and funding agencies should not publicly announce results of biomedical research unless they have received critical review by others in the scientific community.

The AMA as a Public Trust

Disinformation spread by health professionals is not a new phenomenon. In 1906, the AMA formed the Propaganda Department (later renamed the Bureau of Investigation and subsequently the Department of Investigation) to combat unscrupulous medical claims, often by those with professional credentials.^{98, 99} While the public’s trust in many institutions has waned during the COVID-19 pandemic, people still trust their doctors and doctors trust the AMA. In his November 12, 2021, address to the AMA House of Delegates, Dr. Madara noted that, “[t]he AMA exists to benefit the public, but we do so in a very particular way—by being the physicians’ powerful ally in patient care. We serve the public by serving those who care for the public. Supporting physicians and improving our nation’s health has been our focus since 1847.”¹⁰⁰

Following the onset of the pandemic and the growing negative effect of disinformation on public health initiatives to combat COVID-19 the HOD adopted Policy D-440.921, “An Urgent Initiative to Support COVID-19 Vaccination and Information Programs,” which provided that that AMA would institute a program to promote the integrity of a COVID-19 vaccination information by educating the public about up-to-date, evidence-based information regarding COVID-19 and counter misinformation by building public confidence, as well as educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online. This directive informed the AMA’s active participation in the COVID Collaborative in partnership with the Ad Council.

The AMA has also continued to issue press statements, noting the harm of mis- and disinformation on the pandemic, has urged the CEOs of six leading social media and e-commerce companies to assist the effort by combatting misinformation and disinformation about the vaccine on their platforms, and sign on to joint statements addressing mis- and disinformation in prescribing treatments for COVID-19. The AMA has remained a source of trusted information with the COVID-19 resource center which provides physicians with up-to-date information about COVID-19 news, research, vaccines and therapeutics.

Council on Ethical and Judicial Affairs and AMA Membership

Further, the AMA's Council on Ethical and Judicial Affairs (CEJA) has two primary responsibilities. Through its policy development function, it maintains and updates the AMA *Code of Medical Ethics*, and through its judicial function, it promotes adherence to the Code's professional ethical standards. CEJA has continued to publish *Code of Medical Ethics* opinions considering the ethical role of physicians in media as well as in non-clinical settings. CEJA also has the authority to expel or deny membership to the AMA, if the physician has been disciplined by their state board and based upon the egregiousness of the physician's conduct.

CONCLUSION

During the COVID-19 pandemic, disinformation has been of the utmost concern, leading some to describe a secondary "infodemic," wherein permanent harm may be done to the trust in institutions due to the sheer volume of mis- and disinformation spread in a rapidly changing and sensitive environment. Disinformation claims made by health professionals can be directly linked to topics such as the promotion of unproven COVID-19 treatments, false claims of vaccine side effects, and public health guidance that is not evidence-based.

Physicians and health professionals have an ethical and professional responsibility to represent current scientific evidence accurately. The spread of health-related disinformation is unethical and unprofessional and harmful to patients and the public. Health professionals who participate in the media can offer effective and accessible medical perspectives, and they have an ethical obligation to consider how their conduct can affect their medical colleagues, other health care professionals, as well as institutions with which they are affiliated. Health professionals are trusted messengers and the spread of disinformation by a few has implications for the entire profession.

Social media platforms are a known source of disinformation and have been under such intense scrutiny recently that they may be amenable to reforms to bolster their credibility. Individual health professionals tend to be good at fact-checking things they encounter, but by the time something has gone viral, it is far too late. Health information should be treated differently and should be pre-emptively screened prior to it going viral. Health information is rarely so urgent that preventing it from going viral will impact a social media's audience and/or ability to stay socially relevant. Disinformation spreads because it is profitable to do so. Cutting off access to a potential customer base should be of the utmost importance as it is also clear that those who spread disinformation are benefitting from it financially.

Preprints and paywalls represent a clear tension in solving the disinformation crisis. Access to an individual, high-quality life sciences journal can cost thousands of dollars, and research is spread across multiple journals in any given field. Yet free, easy-to-access preprints will often be the only resource accessed by both health professionals and the public seeking to understand complex issues even if they may be rife with errors, conflicts of interest or unsupported conclusions. Best practices around paywalls and preprints to improve access to evidence-based information and analysis are needed.

The dissemination of health-related disinformation by health professionals is a complex topic and one for which a comprehensive strategy will be necessary to protect patients and public health. Such a strategy is outlined in the Appendix. The strategy addresses actions that can be taken by the AMA, by social medial companies, by publishers, state licensing bodies, credentialing boards, state and specialty health professional societies, by those who accredit continuing education to stop the spread of disinformation and protect the health of the public.

RECOMMENDATIONS

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

1. That Policy D-440.914, "Addressing Public Health Disinformation Disseminated by Health Professionals," be amended by addition and deletion to read as follows:
Our AMA will: (1) collaborate with relevant health professional societies and other stakeholders: (a) on efforts to combat public health disinformation disseminated by health professionals in all forms of media, ~~and~~ (b) ~~to~~ address disinformation that undermines public health initiatives ~~by,~~ and (c) implement a comprehensive strategy to address health-related disinformation disseminated by health professionals that includes:
(1) Maintaining AMA as a trusted source of evidence-based information for physicians and patients.

- (2) Ensuring that evidence-based medical and public health information is accessible by engaging with publishers, research institutions and media organizations to develop best practices around paywalls and preprints to improve access to evidence-based information and analysis.
 - (3) Addressing disinformation disseminated by health professionals via social media platforms and addressing the monetization of spreading disinformation on social media platforms.
 - (4) Educating health professionals and the public on how to recognize disinformation as well as how it spreads.
 - (5) Considering the role of health professional societies in serving as appropriate fact-checking entities for health-related information disseminated by various media platforms.
 - (6) Encouraging continuing education to be available for health professionals who serve as fact-checker to help prevent the dissemination of health-related disinformation.
 - (7) Ensuring licensing boards have the authority to take disciplinary action against health professionals for spreading health-related disinformation and affirms that all speech in which a health professional is utilizing their credentials is professional conduct and can be scrutinized by their licensing entity.
 - (8) Ensuring specialty boards have the authority to take action against board certification for health professionals spreading health-related disinformation.
 - (9) Encouraging state and local medical societies to engage in dispelling disinformation in their jurisdictions; and (2) study disinformation disseminated by health professionals and its impact on public health and present a comprehensive strategy to address this issue with a report back at the next meeting of the House of Delegates.
2. That Policies D-440.914, “Addressing Public Health Disinformation Disseminated by Health Professionals,” D-440.915, “Medical and Public Health Misinformation in the Age of Social Media,” and H-460.978, “Communication Among the Research Community, the Media and the Public” be reaffirmed.

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APPENDIX

Comprehensive Strategy Against Medical & Public Health Disinformation

Goal	Objectives/Tactics
Maintain AMA as a trusted source of evidence-based information for physicians and patients.	<ul style="list-style-type: none"> • Provide evidence-based information to physicians. • Undertake public campaigns (like the COVID Collaborative on vaccines) in areas where disinformation is causing patients harm. • Educate health professionals and the public on how to recognize disinformation as well as how it spreads. • Continue to use the AMA's voice to speak out against the spread of health-related disinformation being spread by health professionals. • Maintain that CEJA has the authority to revoke AMA membership for those physicians spreading health-related disinformation.
Ensure that evidence-based information is accessible.	<ul style="list-style-type: none"> • Engage with publishers, research institutions and media organizations to develop best practices around paywalls and preprints to improve access to evidence-based information and analysis. • Discourage the dissemination of results of biomedical research unless they have received critical review by others in the scientific community.
Address disinformation disseminated by health professionals via social media platforms.	<ul style="list-style-type: none"> • Encourage health professionals' usage of social media platforms with robust disinformation policies in place. • Encourage social media platforms to automatically flag health information for de-prioritization in the sharing algorithm (and/or temporarily disabling the "Share" functionality on websites like Facebook) until it has been affirmatively checked by an appropriate fact-checking entity • Consider the role of health professional societies in serving as appropriate fact-checking entities.
Address the monetization of spreading disinformation on social media platforms.	<ul style="list-style-type: none"> • Affirm that all speech in which a health professional is utilizing their credentials is professional conduct and can be scrutinized by their licensing entity. This includes public appearances, social media posts, books, online videos, etc. • Health professionals should be responsible for representations of their professional recommendations in publications. • Upon license renewal, health professionals should be required to disclose all activities in which they have profited from their credential, including activities in which their credential lends credibility as an expert.
Ensure licensing boards have the authority to take disciplinary action against health professionals spreading health-related disinformation.	<ul style="list-style-type: none"> • Advocate for licensing boards to have authority to discipline health professionals spreading health-related disinformation. • Encourage increased transparency regarding the types of complaints referred for investigation, the current status of complaints in the investigation process, and what level of action is taken as a result of investigations. • Expedite timelines to process complaints in the domain of public health disinformation during public health emergencies.
Offer continuing education for health professionals who serve as fact-checker to help prevent the dissemination of health-related disinformation.	<ul style="list-style-type: none"> • Encourage appropriate accrediting bodies to provide health professionals with continuing education credit (or equivalent accreditation maintenance) for engaging with fact-checking organizations. This could be similar to current CME policies which allows health professionals to get credit for peer-reviewing literature. • Encourage trainings to be developed and offered to health professionals on how to address disinformation in ways that account for patients' diverse needs, concerns, backgrounds, and experiences.
Ensure medical specialty boards have the authority to revoke the certification of health professionals for spreading health-related disinformation.	<ul style="list-style-type: none"> • Support the authority of medical specialty boards in taking action against certification due to a diplomate engaging in unethical and unprofessional behavior by spreading disinformation that is harmful to public health.

	<ul style="list-style-type: none"> Encourages medical specialty boards to work with social media platforms to verify and elevate credible sources of health information.
Encourage state and local medical societies, and their equivalents for other health professional organizations, to engage in dispelling health-related disinformation in their jurisdictions.	<ul style="list-style-type: none"> Partner with community groups and other local organizations to prevent and address health disinformation.

16. LANGUAGE PROFICIENCY DATA OF PHYSICIANS IN THE AMA MASTERFILE (RESOLUTION 613-A-19)

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy D-405.971

Resolution 613-A-19, sponsored by the Minority Affairs Section, asks that our American Medical Association initiate collection of self-reported physician language proficiency data in the Masterfile by asking physicians with the validated six-point adapted-ILR scale to indicate their level of proficiency for each language other than English in healthcare settings.

Reference committee testimony demonstrated support for the spirit of the resolution. Additional testimony indicated other sources collect this information though perhaps not at the proficiency level. Based on this testimony, it was agreed that additional study is needed to investigate this issue's complexities.

This report provides an overview of four existing assessment scales for language proficiency as well as the proposed adapted ILR scale for physicians, current state of language-related data collection by our AMA and other entities, related activities of the AMA's Center for Health Equity, relevant AMA policies, and a conclusive summary of this investigational report.

ASSESSMENT SCALES FOR THE MEASUREMENT OF LANGUAGE FLUENCY

Research shows that unlike other industries, healthcare has not yet adopted a standard by which to assess language proficiency. Within this section, four commonly used scales in other industries are summarized. Combined with proper testing, each scale can be used to report a person's language proficiency level as it relates to speaking, reading, listening, and writing. The scales are also used for self-assessment purposes, particularly in instances of employment applications. The section ends with a summary of the scale referenced in Resolution 613.

Interagency Language Roundtable Proficiency Level Descriptions - The Interagency Language Roundtable (ILR) Proficiency Level Descriptions are based on work conducted by the Foreign Service Institute in the mid-1950s. The formal descriptions for the six-level scale were written in 1968 and became part of the US Government Personnel Manual. The base levels range from no proficiency (level 0) to functionally native proficiency (level 5) and are supplemented by plus levels that denote an individual's skill exceeds one base level but does not yet meet the next base level. The ILR scale has influenced the evaluation of foreign language proficiency in the United States and internationally. It is predominantly used throughout the federal government but is also applied by industry and academia.

The ILR is an unfunded federal interagency organization established for the coordination and sharing of information about language-related activities at the federal level. Its membership has professional interests in foreign language use in work-related contexts. The US Department of Health and Human Services is just one of the regularly attending ILR entities.

American Council on the Teaching of Foreign Languages Proficiency Scale - In the 1980s, the American Council on the Teaching of Foreign Languages (ACTFL) developed a proficiency scale for academic use and based it on the ILR proficiency scale. The ACTFL proficiency scale has five levels: novice, intermediate, advanced, superior, and

distinguished. All but the superior and distinguished levels are made up of three sublevels: low, mid, and high. Although the ACTFL scale is the standard measure of proficiency in academia, it is also used by industry.

Founded in 1968, ACTFL is dedicated to the improvement and expansion of the teaching and learning of all languages at all levels of instruction. ACTFL provides testing and rating according to both the ACTFL and ILR proficiency scales. The majority of members come from an academic setting (elementary to graduate level) with other members representing government and industry.

STANAG 6001 Scale - The STANAG 6001 scale is made up of six proficiency levels. It is used primarily by the military in Europe to compare language ability among those who may need to cooperate in military operations.

The North Atlantic Treaty Organization created the scale as a part of its international military standards. Adopted in 1976, STANAG 6001 is based on the ILR scale.

Common European Framework of Reference for Languages Scale - The Common European Framework of Reference for Languages (or CEFR scale) is the popular proficiency scale in Europe. It is a six-level scale that was developed in the 1990s by the Council of Europe. The CEFR scale is used for academic purposes primarily but by other industries as well.

Founded in 1949, the Council of Europe is an intergovernmental cooperation organization.

Adapted Interagency Language Roundtable Scale for Physicians - (Note: Although Resolution 613 advocates use of an adapted International Language Roundtable scale for physicians, it has been confirmed that the author of the resolution intended to state adapted Interagency Language Roundtable scale for physicians.¹⁾

The adapted ILR scale is a simplified version of ILR that features more succinct descriptions revised to apply to a health care conversation, easy to understand description labels, and an absence of sublevels. See Appendix A for a comparison of scale levels and descriptions.

It appears the adapted scale was originally created by Palo Alto Medical Foundation (PAMF) Research Institute researchers to determine best methods for characterizing physician language proficiency. The 2009 study focused on PAMF-affiliated Sutter Health and concluded: “The organization was willing to adopt a relatively straightforward change in how data were collected and presented to patients based on the face validity of initial findings. This organizational policy change [from a marketing-created and undefined three-label scale] appeared to improve how self-reported physician language proficiency was characterized.”²

In 2010, the research team continued its study of the adapted scale focusing on the accuracy of self-assessment using the adapted ILR scale. The team concluded: “Self-assessment of non-English-language proficiency using the ILR correlates to tested language proficiency, particularly on the low and high ends of the scale. Participants who self-assess in the middle of the scale may require additional testing. Further research needs to be conducted to identify the characteristics of primary care providers (PCP) whose self-assessments are inaccurate and, thus, require proficiency testing.”³

CURRENT COLLECTION OF LANGUAGE-RELATED DATA BY OUR AMA

Currently, our AMA does not collect, maintain, or have access to any physician-specific language-related data.

As of 2019, our AMA launched the AMA Center for Health Equity. AMA Health Equity staff acknowledge that collection of such data would benefit strategic work surrounding health literacy. Collecting language proficiency data against a standardized scale has the potential to provide foundational information that may allow the team to develop plans to push upstream and inform the creation and placement of health literacy programs.

It should also be noted that AMA Health Solutions, in collaboration with Medical Education and Health Equity, is working with an industry collaborative group around the collection, maintenance, and use of data to inform work specifically around workforce research and trends and health equity. The categorization and collection of language proficiency information has been identified as an area of interest and is currently scheduled for discussion in 2022. Initial participants include representatives from the Association of American Medical Colleges (AAMC) and

Accreditation Council for Graduate Medical Education (ACGME). The collaborative has recently agreed upon categorization and values for race and ethnicity and is currently discussing sexual orientation and gender identity before turning attention to language proficiency.

COLLECTION OF LANGUAGE-RELATED DATA OUTSIDE OF OUR AMA

A search of language-related data collection specific to physicians reveals a few disparate sources, vehicles, and methods of collection, all of which are self-reported with most collection occurring absent of any proficiency scale. The following summarizes a scan of the market.

The AAMC collects self-reported language proficiency data on the American Medical College Application Service (AMCAS) application. All applicants are required to assess their spoken-language skill for English and any other languages they choose to include using the following scale: basic, fair, good, advanced, or native/functionally native. All scale labels are defined on the application. (See Appendix A) A contact at AAMC was unable to confirm whether the scale was adapted from one of the existing scales summarized in this report but did state that AAMC does not consider their scale proprietary.

Applicants must also indicate how often they spoke the language in their childhood home, choosing from five options: never, rarely, from time to time, often, and always.

Doximity, a physician social network, collects self-reported physician language data, but it is not clear whether Doximity records proficiency level. Doximity used this language data to publish a 2017 research study titled “Language Barriers in US Health Care.”⁴ The study compared languages (other than English) spoken by US physicians against the US Census Bureau’s American Community Survey data on spoken languages. It reported the top 10 patient languages with the least overlap with US doctors and the top 10 metro areas with a significant language gap.

The Medical Board of California conducts a physician survey⁵ of allopathic physicians and surgeons at the time of license renewal. The goal of the mandated survey is to better understand California’s physician workforce. Among other things, the survey questions licensees about their foreign language fluency; a response is voluntary. With this data, the Medical Board of California publishes an annual report about languages spoken (not proficiency) as segmented by county. The report is accessible via the HealthData.gov site.⁶

CAQH, a non-profit alliance of health plans and trade associations, offers clinicians free use of its CAQH ProView web-based solution. CAQH claims that more than 1.4 million clinicians use ProView to self-report and share demographic and professional information with participating health plans, hospitals, health systems and provider groups for credentialing, network directory, and claims administration purposes.⁷ The CAQH online application asks physicians to provide information on the non-English languages they speak.

A search of physician employment/appointment applications that can be viewed online shows a fairly even split of those that ask about foreign languages spoken versus those that do not. Of those collecting language data, no application asked for details about proficiency.

The Federation of State Medical Boards offers the Uniform Application for Licensure program, a web-based licensing application that allows physicians and physician assistants to enter core application data once and then submit that information to any of the 27 participating boards. The Uniform Application does not collect any language data, therefore, the assumption can be made that those boards are not collecting language data via licensing.

A review of applications from five state medical boards that do not use the Uniform Application shows that language data is not collected at the time of application.

This quick scan demonstrates that at least 45% of state medical boards do not collect language data through the licensing application itself.

DISCUSSION

There are two fundamental issues to address when considering this work. First, the absence of a common standard by which this data is collected presents challenges and limits the value and usefulness of the data. The lack of a common

standard results in disparate data sets with varying applicability for research limiting the ability to draw conclusions and make important program recommendations. The AMA is currently working with AAMC and ACGME to identify standards for data collection and maintenance of data that informs workforce research and health equity. This industry collaboration, in conjunction with input from other industry stakeholders, is well positioned to identify the common standard that should be used in the collection of language proficiency in the healthcare setting. The second challenge is around the avenue and point of collection. The AMA can certainly collect this information through its own proprietary collection vehicles. The most practical method of data collection would be to add this question to the AMA's Account Management Center (AMC). This approach, however, would not yield as comprehensive of a dataset as working with other stakeholders to add this dimension to standard applications.

AMA POLICY

The AMA has several policies related to language and clear physician-patient communication (see Appendix B). The majority of these policies regard the use of and payment for language interpreters and interpretive services. Policy H-160.914 encourages the use of multilingual patient assessment tools. Policy H-295.870 encourages medical schools offer students medical second language courses, such as medical Spanish.

SUMMARY

The collection of this information is directly related to the work of the AMA's Center for Health Equity. As such, this work should not be done in isolation and instead should be informed by the overall strategy and work of the center. A scan of the market shows that while some organizations are collecting information on languages spoken, most are lacking a meaningful proficiency measurement and are collecting data at a specific point in time without a clear path to update the data over time. Most notably, the AAMC is collecting information as part of the medical school application process. This allows them to collect data on a large scale—all medical school applicants—but does not afford them the ability to update this information throughout a physician's career.

The industry would benefit from agreement on the appropriate data collection methods, values, and scale. The AMA, AAMC and ACGME have formed an industry collaborative to discuss the collection, maintenance, and access to data that will inform improvements in health equity and workforce analysis. Language proficiency has been identified as an area of interest and is current scheduled to be discussed in 2022.

RECOMMENDATIONS

In lieu of Resolution 613-A-19, it is recommended 1) that our AMA continue its work with other industry stakeholders to identify best practices, including adoption of a national standard, for the collection of self-reported language proficiency and 2) that in the event a national standard for the collection of self-reported language is identified, our AMA Masterfile will include this proficiency in the data file and the remainder of this report be filed.

ENDNOTES

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APPENDIX A - Comparison of ILR, Adapted ILR, and AAMC AMCAS Descriptions for Speaking

ILR (Base levels only)	Adapted ILR	AAMC AMCAS
<p>0: No Proficiency Unable to function in the spoken language. Oral production is limited to occasional isolated words. Has essentially no communicative ability.</p>		
<p>1: Elementary Proficiency Able to satisfy minimum courtesy requirements and maintain very simple face-to-face conversations on familiar topics. A native speaker must often use slowed speech, repetition, paraphrase, or a combination of these to be understood by this individual. Similarly, the native speaker must strain and employ real-world knowledge to understand even simple statements/questions from this individual. This speaker has a functional, but limited proficiency. Misunderstandings are frequent, but the individual is able to ask for help and to verify comprehension of native speech in face-to-face interaction. The individual is unable to produce continuous discourse except with rehearsed material.</p>	<p>Poor Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2- to 3-word entry-level questions. May require slow speech and repetition to understand. Unable to understand or communicate most healthcare concepts.</p>	<p>Basic I speak the language imperfectly and only to a limited degree and in limited situations. I have difficulty in or understanding extended conversations.</p>
<p>2: Limited Working Proficiency Able to satisfy routine social demands and limited work requirements. Can handle routine work-related interactions that are limited in scope. In more complex and sophisticated work-related tasks, language usage generally disturbs the native speaker. Can handle with confidence, but not with facility, most normal, high-frequency social conversational situations including extensive, but casual conversations about current events, as well as work, family, and autobiographical information. The individual can get the gist of most everyday conversations but has some difficulty understanding native speakers in situations that require specialized or sophisticated knowledge. The individual's utterances are minimally cohesive. Linguistic structure is usually not very elaborate and not thoroughly controlled; errors are frequent. Vocabulary use is appropriate for high-frequency utterances, but unusual or imprecise elsewhere.</p>	<p>Fair Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school, and family. Has difficulty with vocabulary and grammar. The individual can get the gist of most everyday conversations but has difficulty communicating about healthcare concepts.</p>	<p>Fair I speak and understand well enough to have extended conversations about current events, work, family, or personal life. Native speakers notice many errors in my speech or my understanding.</p>
<p>3: General Professional Proficiency Able to speak the language with sufficient structural accuracy and vocabulary to participate effectively in most formal and informal conversations in practical, social and professional topics. Nevertheless, the individual's limitations generally restrict the professional contexts of language use to matters of shared knowledge and/or international convention. Discourse is cohesive. The individual uses the language acceptably, but with some noticeable imperfections; yet, errors virtually never interfere with understanding and rarely disturb the native speaker. The individual can effectively combine structure and vocabulary to convey his/her meaning accurately. The individual speaks readily and fills pauses suitably. In face-to-face conversation with natives speaking</p>	<p>Good Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics. Although cultural references, proverbs and the implications of nuances and idiom may not be fully understood, the individual can easily repair the conversation. May have some difficulty communicating necessary health concepts.</p>	<p>Good I speak well enough to participate in most conversations. Native speakers notice some errors in my speech or my understanding, but my errors rarely cause misunderstanding.</p>

ILR (Base levels only)	Adapted ILR	AAMC AMCAS
<p>the standard dialect at a normal rate of speech, comprehension is quite complete. Although cultural references, proverbs and the implications of nuances and idiom may not be fully understood, the individual can easily repair the conversation. Pronunciation may be obviously foreign. Individual sounds are accurate: but stress, intonation and pitch control may be faulty.</p>		
<p>4: Advanced Professional Proficiency Able to use the language fluently and accurately on all levels normally pertinent to professional needs. The individual's language usage and ability to function are fully successful. Organizes discourse well, using appropriate rhetorical speech devices, native cultural references and understanding. Language ability only rarely hinders him/her in performing any task requiring language; yet, the individual would seldom be perceived as a native. Speaks effortlessly and smoothly and is able to use the language with a high degree of effectiveness, reliability and precision for all representational purposes within the range of personal and professional experience and scope of responsibilities. Can serve as an informal interpreter in a range of unpredictable circumstances. Can perform extensive, sophisticated language tasks, encompassing most matters of interest to well-educated native speakers, including tasks which do not bear directly on a professional specialty.</p>	<p>Very Good Able to use the language fluently and accurately on all levels related to work needs in a healthcare setting. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech. Language ability only rarely hinders him/her in performing at task requiring language; yet, the individual would seldom be perceived as a native.</p>	<p>Advanced I speak very accurately, and I understand other speakers very accurately. Native speakers have no problem understanding me, but they probably perceive that I am not a native speaker.</p>
<p>5: Functionally Native Proficiency Speaking proficiency is functionally equivalent to that of a highly articulate well-educated native speaker and reflects the cultural standards of the country where the language is natively spoken. The individual uses the language with complete flexibility and intuition, so that speech on all levels is fully accepted by well-educated native speakers in all of its features, including breadth of vocabulary and idiom, colloquialisms and pertinent cultural references. Pronunciation is typically consistent with that of well-educated native speakers of a non-stigmatized dialect.</p>	<p>Excellent Speaks proficiently, equivalent to that of an educated speaker, and is skilled at incorporating appropriate medical terminology and concepts into communication. Has complete fluency in the language such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural references.</p>	<p>Native/Functionally Native I converse easily and accurately in all types of situations. Native speakers may think that I am a native speaker, too.</p>

APPENDIX B - Related AMA Policies and Standards

H-160.914, “Support of Multilingual Assessment Tools for Medical Professionals”

Our AMA will encourage the publication and validation of standard patient assessment tools in multiple languages.

H-160.924, “Use of Language Interpreters in the Context of the Patient-Physician Relationship”

AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (2) treating physicians shall respect and assist the patients’ choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools’ limitations--to aid LEP patients’ involvement in meaningful decisions about their care; and (4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services’ policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.

H-215.982, “Interpretive Services”

Our AMA encourages hospitals and pharmacies that serve populations with a significant number of non-English speaking or hearing-impaired patients to provide trained interpretive services.

H-295.870, “Medical School Language Electives in Medical School Curriculum”

Our AMA strongly encourages all Liaison Committee on Medical Education- and American Osteopathic Association-accredited US medical schools to offer medical second languages to their students as electives.

H-350.956, “Increasing Access to Healthcare Insurance for Refugee Populations”

Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health care for refugees.

H-385.917, “Interpreter Services and Payment Responsibilities”

Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient’s emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services.

H-385.928, “Patient Interpreters”

Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government.

H-385.929, “Availability and Payment for Medical Interpreters Services in Medical Practices”

It is the policy of our AMA to: (1) the fullest extent appropriate, to actively oppose the inappropriate extension of the OCR LEP guidelines to physicians in private practice; and (2) continue our proactive, ongoing efforts to correct the problems imposed on physicians in private practice by the OCR language interpretation requirements.

D-90.999, “Interpreters For Physician Visits”

Our AMA continues to monitor enforcement of those provisions of the ADA to assure that physician offices are not subjected to undue burdens in their efforts to assure effective communication with hearing disabled patients.

D-160.992, “Appropriate Reimbursement for Language Interpretive Services”

1. Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English.
2. Our AMA will seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care.

D-385.957, “Certified Translation and Interpreter Services”

Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.

D-385.978, “Language Interpreters”

Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services; (2) redouble its efforts to remove the financial burden of medical interpretive services from physicians; (3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement; (4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and (5) work with governmental officials and

other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense.

AMA Code of Medical Ethics

Code of Medical Ethics Opinion E-2.1.1, “Informed Consent”

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

The process of informed consent occurs when communication between a patient and physician results in the patient’s authorization or agreement to undergo a specific medical intervention. In seeking a patient’s informed consent (or the consent of the patient’s surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

- (a) Assess the patient’s ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
- (b) Present relevant information accurately and sensitively, in keeping with the patient’s preferences for receiving medical information. The physician should include information about:
 - 1. The diagnosis (when known)
 - 2. The nature and purpose of recommended interventions
 - 3. The burdens, risks, and expected benefits of all options, including forgoing treatment
- (c) Document the informed consent conversation and the patient’s (or surrogate’s) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record. In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient’s surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

Code of Medical Ethics Opinion E-8.5, “Disparities in Health Care”

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients’ clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

- (a) Provide care that meets patient needs and respects patient preferences.
- (b) Avoid stereotyping patients.
- (c) Examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
- (d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
- (e) Encourage shared decision making.
- (f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients’ health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

- (g) Help increase awareness of health care disparities.
- (h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
- (i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

17. EXPUNGEMENT, DESTRUCTION, AND SEALING OF CRIMINAL RECORDS FOR LEGAL OFFENSES RELATED TO CANNABIS USE OR POSSESSION

Reference committee hearing: see report of Reference Committee B.

**HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 213
REMAINDER OF REPORT FILED**
See Policy H-95.910

INTRODUCTION

At the November 2020 Special Meeting of the AMA House of Delegates (HOD), Policy D-95.960 was adopted asking “That our AMA study the expungement, destruction, and sealing of criminal records for legal offenses related to cannabis use or possession.”

During the meeting, there was testimony in support of an amendment on the expungement of criminal records for cannabis-related offenses. The AMA Council on Legislation testified that given the legal nature of the proposed recommendation, the issue would benefit from further study. This report discusses the issues raised and provides general information and background for the purposes of informing the AMA HOD. This report should not be relied upon as legal advice or for applicability to any particular factual scenario. An individual interested in pursuing legal action related to the issues raised in this report should consult with a licensed attorney in the state in which the individual resides or action in question occurred. This report also provides relevant AMA policy and presents recommendations for HOD consideration.

BACKGROUND

The legal status of cannabis is a patchwork of state and federal law and federal guidance. Colorado and Washington were the first states to legalize cannabis for medical use in 2012. In 2013, the U.S. Department of Justice (DOJ) issued what is referred to as the “Cole Memo.” The Cole Memo essentially stated that the federal government would not interfere with state cannabis laws if the state had a strict regulatory system to protect against criminal activity.¹ At least eight states legalized medical cannabis between 2013-2018. In 2018, the DOJ rescinded the Cole Memo.²

Currently, adult use of cannabis is legal in at least 18 states and two territories, and for medical use, cannabis is legal in at least 37 states and four territories.³ Cannabis remains a Schedule I Controlled Substance at the federal level, which is defined as having, “a high potential for abuse...no currently accepted medical use in treatment in the United States...[and] There is a lack of accepted safety for use of the drug or other substance under medical supervision.”⁴

Between 2010 and 2018, there were more than six million arrests related to cannabis. Young people and young adults are the ones primarily arrested, and when charged, prosecuted, or incarcerated, may suffer significant trauma.⁵ People who are Black are 3.6 times more likely to be arrested than people who are white, despite similar rates in usage. Even following legalization, disparities in arrest rates continue.⁶

Issues relating to expungement should not, however, be confused with issues relating to the health effects of cannabis use on youth and adolescents. Researchers have found that, “Marijuana use has been associated with several adverse mental health outcomes, including increased incidence of addiction and comorbid substance use, suicidality, and new-onset psychosis. Negative impacts on cognition and academic performance have also been observed.”⁷ A study looking at youth perception of risk done when only eight states legalized cannabis for medical use found youth in these states tended to use cannabis more frequently than in states that did not legalize its use and that youth had lower perceptions of health risks associated with cannabis use.⁸

DISCUSSION

As a threshold matter, it is important to recognize that expungement, destruction, and sealing are legal processes. An expungement process may involve multiple steps where the end result is to remove a record of arrest and/or conviction from the official state or federal record. The idea is that post-expungement, the record never existed. While an expungement may “erase” a record, “sealing” hides the record from public view. More specifically, when “sealed,”

the record can be accessed under certain circumstances.⁹ Finally, “destruction” of a record generally means to physically destroy it. When a record is “destroyed,” there is no record remaining whatsoever.¹⁰ It is important to note that specific definitions may vary by state.

The Council on Science and Public Health (CSAPH) has previously discussed how having a criminal record can negatively affect an individual’s employment, housing, education, receipt of public benefits, and other social determinants of health and public health effects.¹¹ There are additional implications for medical students,¹² residents, and other physicians who, if there is a record of a prior cannabis possession arrest or conviction, may be asked to disclose that record on a licensing or employment application. As discussed below, depending on the applicable state and/or federal law, it may not be clear whether expungement or sealing requires or protects against future disclosure. It is beyond the scope of this report to discuss in depth what might occur if a medical student, resident, or physician does disclose the existence of a prior arrest or conviction for a cannabis-related offense.

Under federal law, the record of a conviction for drug possession may be able to be expunged depending on the circumstances. An individual must qualify for expungement and undertake the process to formally seek expungement. There are different requirements for those 21 years of age and older and those younger than 21. The record of the underlying expungement also offers protection against future adverse use, but it is retained by the DOJ.¹³

Approximately 20 states have enacted laws or other policies providing for expungement, record sealing, or other similar actions based on acts that are no longer crimes post-enactment of cannabis legalization.^{14,15} Illinois, for example, has created a detailed pathway for expungement of cannabis-related offenses. The specific process and qualification for potential expungement, including automatic expungement, depends on whether the arrest was “minor,” the date of the arrest, whether the individual was an adult or minor, how long it has been since the arrest, whether there were charges filed, amount of cannabis for which the arrest occurred, and other factors.¹⁶ Under California’s Proposition 64, acts that were committed prior to the legalization of adult use cannabis, were made eligible for resentencing, dismissal, or sealing.¹⁷ As in Illinois, eligibility for expungement and sealing of records in California is subject to a wide variety of different requirements. Approximately 500,000 cannabis-related arrest records have been expunged in Illinois following enactment of the law.¹⁸ Despite a law requiring records of cannabis-related offenses to be sealed in California, hundreds of thousands of records remain open, according to pro-cannabis sources.¹⁹

Substantial barriers to expungement remain,²⁰ depending on the state, including individual petition requirements, complex filing processes necessitating legal representation, filing fees, hearings without sufficient notice, fingerprinting requirements, and ineligibility due to unpaid debt—even when this debt (fines, fees, or restitution) is related to the offense being expunged.²¹ Further, there is evidence of disparate access to expungement for historically marginalized and minoritized individuals. In fact, a 2017 study reviewing Wisconsin expungements showed that:

[s]tatewide, only 10 percent of those granted expungements since 2010 are African-American and only 2 percent are Hispanic—much lower numbers than appear to have been eligible (23 percent and 6 percent, respectively). Conversely, statewide, 79 percent of those granted expungements were white, while only 63 percent of those generally eligible were white.²²

Even if a record is expunged or sealed, however, that may not address collateral consequences of the arrest or conviction, e.g., potential professional licensing sanctions, adverse employment actions, and qualification for government benefits, including loans and housing. These collateral consequences can also suppress the local tax base by locking people into unemployment or lower paying jobs and increase taxpayer costs due to increasing likelihood of further involvement in the criminal legal system.²³ As noted by Marion County (Indiana) prosecutor Terry Curry, “If our goal is to have individuals not reoffend, then in our mind it’s appropriate to remove obstacles that are going to inhibit their ability to become productive members of our community.”

Finally, very few states have enacted laws addressing these collateral effects, and these issues remain controversial at the federal level.²⁴ In addition, state-specific expungement laws have trailed behind legalization efforts.²⁵ Potential interstate conflicts also may arise when an individual has an arrest or conviction in one state but then goes on to reside in a different state. Further complicating the issue, is the fact that without legal representation, it may not be clear whether an individual should seek expungement, sealing, or other legal avenues. This is why the Lawyers’ Committee for Civil Rights Under the Law emphasizes that the legal strategy depends on the situation.²⁶

In addition, the net social benefits to expungement should not be used to set aside or minimize the health risks associated with cannabis use—particularly for youth and adolescents. Even when states take action to positively address legal inequities and support social determinants of health, there remain significant adverse health effects of cannabis use for youth and adolescents.

AMA POLICY CONSIDERATIONS

The AMA opposes legalization of cannabis for medical use, “through the state legislative, ballot initiative, or referendum process.” (D-95.969, “Cannabis Legalization for Medicinal Use”) As explained above, however, expungement of cannabis-related offenses is a process that occurs after-the-fact. The AMA also opposes legalization of cannabis for adult use while supporting, “public health-based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use.” (H-95.924, “Cannabis Legalization for Adult Use” [commonly referred to as recreational use]) The expungement process—to the extent that it helps prevent the loss of public health benefits and supports the continuity of social determinants of health—is in line with a public health-based strategy.

Consistent with this report, the AMA also, “encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; [and] encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis.” (H-95.924, “Cannabis Legalization for Adult Use” [commonly referred to as recreational use]).

The AMA also supports, “fairness in the expungement and sealing of records” for juveniles. (H-60.916, “Youth Incarceration in Adult Facilities”) The AMA further, “[e]ncourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system” (H-60.919, “Juvenile Justice System Reform”). As discussed above, arrest and conviction rates for cannabis possession are disproportionately felt by Black and Brown youth and adults. As a result, policies and procedures to facilitate expungement or other legal strategies would appear beneficial to restore future rights and benefits.

Fundamental fairness and equity principles argue that individuals with an arrest or conviction for cannabis-related offenses—that occurred before legalization that would make such action legal—should not suffer further legal or public health adverse effects. Such a direction from the AMA would not alter its underlying policy opposing legalization of cannabis for medical or adult use. Supporting efforts to improve public health effects, however, would be directly in line with AMA policy on numerous fronts, including support for youth adversely affected by the justice system. Analyzing the relative strengths and weaknesses of every state’s expungement, sealing, and other policies, is beyond the scope of this report. There are, however, multiple national and other resources the AMA could provide as guidance to others when considering options relating to post-arrest and post-conviction policies in states that have legalized cannabis for medical or adult use.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) support automatic expungement, sealing, and similar efforts regarding an arrest or conviction for a cannabis-related offense for use or possession that would be legal or criminalized under subsequent state legalization or decriminalization of adult use or medicinal cannabis.
2. That our AMA support automatic expungement, sealing, and similar efforts regarding an arrest or conviction of a cannabis-related offense for use or possession for a minor upon the minor reaching the age of majority.
3. That our AMA inquire to the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, Federation of State Medical Boards, and other relevant medical education and licensing authorities, as to the effects of disclosure of a cannabis related offense on a medical school, residency, or licensing application.
4. That our American Medical Association (AMA) support ending conditions such as parole, probation, or other court-required supervision because of a cannabis-related offense for use or possession that would be legal or decriminalized under subsequent state legalization or decriminalization of adult use or medicinal cannabis.

5. That AMA Policy D-95.960, “Public Health Impacts of Cannabis Legalization,” be rescinded since this report fulfills the directive contained in the policy.

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18. ADDRESSING INFLAMMATORY AND UNTRUTHFUL ONLINE RATINGS (RESOLUTION 702-JUN-21)

Reference committee hearing: see report of Reference Committee G.

**HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 702-JUN-21
REMAINDER OF REPORT FILED
See Policy D-445.997**

INTRODUCTION

At the June 2021 Special Meeting of the House of Delegates Resolution 702-Jun-21, "Addressing Inflammatory and Untruthful Online Ratings," was introduced by the New York Delegation and referred for report back. This resolution asks the American Medical Association (AMA) to take action that would urge online review organizations to create internal mechanisms ensuring due process to physicians before the publication of negative reviews.

This report discusses the concerns associated with online ratings of physicians and their practices, AMA's efforts to support physicians in managing their online reputations, and the various legal and privacy implications that physicians may face when responding to patient ratings and reviews. Also included in this report are recommendations for physicians to follow when considering addressing or responding to patient ratings, based on available resources. Finally, this report makes recommendations for AMA policy and the development of resources that can further support physicians in managing their practice's online reputation.

It should be noted that, in considering what constitutes "online reviews" for the purposes of this report, not all reviews posted about physicians are created by patients, and there is no known process to screen reviewers to verify patient status. For example, some negative or false reviews could be posted by disgruntled former employees, ex-spouses or ex-partners, and even competitors or individuals who have personal disagreements with a physician. In addition, some physicians have experienced incidents in which vaccine skeptics, who were not patients, posted negative and false reviews simply on the basis of disagreement with the physician about vaccines. There is currently no formal redress for this problem and few rating sites will remove these false posts.

BACKGROUND

Online rating platforms are an indelible presence on the internet, offering consumers increased transparency into the products and services in which they invest. Health care services are no exception. Numerous websites provide patients with information about their clinicians, including locations, specialties, clinical interests, insurance accepted, and oftentimes reviews from other patients or members of the public. Recent data shows that little more than one-third (37%) of patients use online reviews as their first step in searching for a new physician and 60% of patients have selected a physician based on positive reviews.¹ Incongruously, other research shows a higher percentage of patients (70%) use online reviews in selecting a physician.² Google My Business is a popular source of online reviews for many businesses, including health care practices and physicians. In addition, a 2017 study showed the online review site used most frequently was Yelp.com, followed by Healthgrades.com, and then by the health system, hospital, or group practice website. Nearly 70% of respondents in this study had never used an online review site for health care services. More of those that *did* use one of these sites did so to learn more about a physician or hospital rather than to post a comment.³ In addition, 83% of patients say they *trust* online ratings and reviews of physicians¹, despite other research showing online ratings of physicians do not predict objective measures of quality of care or clinical performance.⁴ Moreover, a 2018 Brookings article shows patients prefer online reviews to government ratings, such as the ratings provided by the Centers for Medicare and Medicaid Services (CMS), when choosing a doctor.⁵

In the information age, when social media and online reputations have such a large role in consumer decision-making, it is clear online review sites are not going away. Physicians, patients, and the sites that provide the forum for online reviews must coexist in a balanced way that provides patients and consumers the transparency to which they are

accustomed, but also allows physicians the ability to respond to reviews and address concerns safely and professionally.

AMA POLICY

The AMA recognizes the threat that negative and inflammatory reviews can pose to a physician's and practice's reputation. AMA policy encourages the adoption of guidelines and standards governing the public release and accurate use of physician data and directs the AMA to identify and offer tools to physicians that allow them to manage their online profile and presence (Policy D-478.980, "Anonymous Cyberspace Evaluations of Physicians").

AMA policy also supports the creation of laws to better protect physicians from cyber-libel, cyber-slander, cyber-bullying and the dissemination of internet misinformation and provides for civil remedies and criminal sanctions for the violation of such laws. (Policy D-478.980, "Anonymous Cyberspace Evaluations of Physicians").

In addition, policy supports legislation that would require that websites purporting to offer evaluations of physicians state prominently on their websites whether or not they are officially endorsed, approved or sanctioned by any medical regulatory agency or authority or organized medical association including a state medical licensing agency, state department of health or medical board, and whether or not they are a for-profit independent business and have or have not substantiated the authenticity of individuals completing their surveys (Policy D-478.980, "Anonymous Cyberspace Evaluations of Physicians").

The AMA *Code of Medical Ethics* Opinion E-2.3.2 includes guidance for physicians in maintaining and protecting their online presence.

1. Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.
2. When using social media for educational purposes or to exchange information professionally with other physicians, follow ethics guidance regarding confidentiality, privacy and informed consent.
3. When using the internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the internet, content is likely there permanently. Thus, physicians should routinely monitor their own internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.
4. If they interact with patients on the internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethics guidance just as they would in any other context.
5. To maintain appropriate professional boundaries physicians should consider separating personal and professional content online.
6. When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.
7. Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students) and can undermine public trust in the medical profession.

DISCUSSION

Because patients often put their trust in online reviews in choosing a physician, physicians have a meaningful stake in ensuring online reviews of them and their practice are truthful and positive. Survey data show the majority of physician reviews are positive, and that negative reviews are less frequent.² This survey also demonstrated that patients largely disregard negative reviews, and more than a third of patients will ignore a review if the physician responded to the concern (Software Advice 2020). Evidence shows the majority of negative reviews are not associated with clinical factors, but more commonly describe experiences such as long wait times, poor parking, or lack of physician attention.⁶ It has also been reported that negative reviews may be more frequent for physicians on probation⁷, those with larger patient panels and busier practices, and those who bill for more services.⁸ For many physicians, inflammatory, false, or extremely negative reviews can be damaging, inflicting moral injury and threatening their practice. For example,

there are instances in which one patient or reviewer will go to multiple rating sites to criticize or disparage a physician and will do so repeatedly over time, sometimes from different IP addresses, flooding the sites with negative comments and creating a false impression that the doctor has many negative reviews. This could prevent new patients from seeking care at that practice or from that physician.

Health care quality reporting has grown in importance, and information about patient experiences and satisfaction is available in many forms. Unlike other businesses that may respond to online reviews however they deem appropriate, physicians are limited in how they can communicate with a patient in a public forum.

Privacy concerns

There are concerns that negative, inflammatory, or untruthful patient reviews, although they may be the exception, can adversely and sometimes seriously affect a physician, their practice, or their career. Physicians may feel compelled to respond to negative online reviews to dispel false information or address the patients' concerns. There are limitations, however, to the ways physicians can respond to patients' online reviews since acknowledgement of a patient's visit might risk violating patient privacy protected by the Health Insurance Portability and Accountability Act (HIPAA). It is important to note that HIPAA does not explicitly prohibit physicians from responding to online reviews; physicians are free to respond to contribute to an online review forum, but they must maintain the privacy of the patient's protected health information, even if the patient has already revealed personal information. While a patient is free to share any information about their visit in an online forum, physicians are prohibited from disclosing any patient information. Examples of this include defending a treatment decision or acknowledging that the reviewer was a patient. Violations of HIPAA may be reported by patients to the federal agency overseeing enforcement, the Department of Health and Human Services Office for Civil Rights (OCR), which responds to such reports with a range of actions from investigation and corrective action plans to significant financial penalties. Additionally, physicians may face legal or financial consequences under state law if the physician practices in a state granting individuals a private right of action for privacy violations.

Additional legal considerations

In addition to privacy concerns, the wrong type of physician response to a patient's online review can have far more serious consequences for a physician's practice than the review itself. If a reviewer's comments are so damaging or untrue that they subsequently affect the physician's ability to safely practice medicine, interfere with the physician's other patient relationships, result in loss of business, or threaten the safety of the physician or other practice employees, the physician may choose to seek legal action against the reviewer. Pursuing legal action against a patient or their family for defamation may come with further reputational damage and will present considerable costs, which should be considered when deciding how to manage such a situation. On the other hand, if a patient or other reviewer is spreading misinformation or disinformation about the physician or practice, action by the physician and legal team may help mitigate the issue and decrease the risk of further reputational damage and thus should be considered.

Solutions

Resolution 702-Jun-21 proposes that online review site organizations should provide physicians due process before publishing negative reviews and that the AMA should take action to encourage the development of these mechanisms.

First, physicians should be aware that online review sites have little to no incentive to develop such mechanisms. One of their primary objectives is to facilitate free speech and provide a forum for honest patient feedback. These sites are protected by law in a way that precludes them from liability for what is posted on their site by users. Under Section 230 of the Communications Decency Act of 1996, online websites with patient reviews are protected from most litigation. This section of the Act is a key part of U.S. law that protects freedom of expression and innovation on the internet. Section 230 says that "No provider or user of an interactive computer service shall be treated as the publisher or speaker of any information provided by another information content provider" (47 U.S.C. § 230).⁹ Essentially, online intermediaries that host or republish speech (e.g., patient reviews) are protected against a range of laws that might otherwise be used to hold them legally responsible for what others say and do.¹⁰ It should be noted, however that most, if not all, online review sites have openly published community review guidelines or standards. Physicians and practices do have the option to contact the review sites directly to dispute false or inflammatory reviews, especially if they believe the reviews violate the site's community standards.

Second, the AMA does not have the authority to dictate due process for private companies. Encouraging physicians to attempt to filter negative reviews from public view could be perceived as a pressure tactic to censor patients or throttle their ability to speak freely. The AMA's Government Affairs staff has contemplated seeking legislative action to address this concern at the federal level, however, it has determined that the political environment would not be favorable to achieving this legislative change and opening up federal health information privacy laws could have the unintended consequence of imposing additional requirements on physician practices, reducing patient data confidentiality protections, and limiting the ways physicians can exchange protected health information.

It is ultimately the onus of the organization, practice, and physician to protect their reputations, both on and off the internet. Organizational policies, particularly for hospitals and larger practices, can help provide guidance and guardrails for employees. There is an abundance of online resources that recommend best practices and can help physicians and organizations learn how to navigate their online reputations, including how to handle negative or inflammatory patient reviews. The American Hospital Association and Medical Group Management Association, for example, both offer online guidance on managing online and social media presence.^{11, 12}

It may be tempting to try to prevent negative reviews by prohibiting patients, via signed agreement, from writing negative reviews about the physician or practice in exchange for the practice's compliance with the HIPAA Privacy Rule. This is not an appropriate mechanism to prevent negative commentary and could result in complaints against the practice or physician, or investigation by the OCR. In addition, the Consumer Review Fairness Act prohibits sellers from offering contracts with provisions that prohibit or restrict individuals from reviewing the seller's goods, services, or conduct.¹³

In considering online review sites as a potentially valuable platform that can help generate or expand business, physicians may find ways to maximize overall reviews to minimize the weight and effects of the few negative comments such as by asking patients who are openly happy with the care they have received to post reviews. It is important to note that extreme points of view, provided by a minority of patients, should not be viewed as a singular barometer of a physician's practice. However, there may be times that criticism may help physicians find ways to improve care and satisfaction for all their patients. Even if patient reviews shed more light on subjective measures of satisfaction than objective treatment outcomes, the information can still be relevant and valuable to both future patients and the practice. For example, patient reviews can provide direct insight into their patients' communication preferences and priorities as a recipient of health care services. Negative reviews can sometimes be interpreted constructively, and physicians can consider whether changing certain aspects of their practices might be in their best professional interests, as well as their patients' best interests.

The AMA has historically been mindful of the problems online patient reviews can pose for physicians. In 2011 the AMA established a partnership with Reputation.com through its member value program, which provided physicians and practices access to a service that helps manage online reputations. Participation in this program by AMA members was extremely low, so the partnership with Reputation.com was discontinued.

The AMA recently submitted comments to the OCR in response to a Notice of Proposed Rulemaking (NPRM) explaining physicians' concerns about their lack of ability to respond to online complaints and inflammatory reviews without violating patient privacy. The AMA encouraged the OCR to develop a mechanism for physicians to respond to online patient complaints without violating HIPAA's privacy protections.¹⁴ The AMA will continue to advocate for such a mechanism in future comments and requests to the OCR.

In 2016 the AMA published an article¹⁵ to guide physicians in how to respond to negative online reviews, and an earlier AMA article advised physicians on managing their online reputation.¹⁶ The AMA is also currently developing a content page within its Debunking Regulatory Myths collection to highlight and clarify the common misconceptions about responding to online patient reviews. This resource will include links to other published information on physician practice online reputation management and will be promoted through AMA communication channels to encourage engagement and attention to the issue.

CONCLUSION

In this age of at-our-fingertips information and open forums for the free exchange of opinions, and with the increased attention to and regulation of care quality, it is undeniable that physicians will need to continue managing their online presence and reputation. It is clear that while online reviews can be helpful, they can also be devastating to a physician

or practice. The AMA recognizes the damage a practice can sustain from false or inflammatory reviews, and in no way condones the allowance of such misinformation and disinformation to be propagated. While it may not be feasible, from a legal or policy perspective, to intervene *before* reviews are posted, thoughtfully and compliantly responding to patient reviews to reconcile issues is possible. This may include working with the website owners to rectify false reviews or reviews that otherwise violate the site's community guidelines. Whether and how that is achieved is up to each physician and their practice to carefully and intentionally manage.

RECOMMENDATION

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 702-Jun-21 and the remainder of the report filed:

That our American Medical Association⁽¹⁾ encourages physicians to take an active role in managing their online reputation in ways that can help them improve practice efficiency and patient care; (2) encourages physician practices and health care organizations to establish policies and procedures to address negative online complaints directly with patients that do not run afoul of federal and state privacy laws; (3) will develop and publish educational material to help guide physicians and their practices in managing their online reputation, including recommendations for responding to negative patient reviews and clarification about how federal privacy laws apply to online reviews; and (4) will work with appropriate stakeholders to (a) consider an outlet for physicians to share their experiences and (b) potentially consider a mechanism for recourse for physicians whose practices have been affected by negative online reviews, consistent with federal and state privacy laws.

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19. DEMOGRAPHIC REPORT OF THE HOUSE OF DELEGATES AND AMA MEMBERSHIP

Informational report; no reference committee hearing.

HOD ACTION: FILED

INTRODUCTION

This informational report, “Demographic Report of the House of Delegates and AMA Membership,” is prepared pursuant to Policy G-600.035, “House of Delegates Demographic Report,” which states:

A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

In addition, this report includes information pursuant to Policy G-635.125, “AMA Membership Demographics,” which states:

Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

This document compares the House of Delegates (HOD) with the entire American Medical Association (AMA) membership and with the overall United States physician and medical student population. Medical students are included in all references to the total physician population throughout this report to remain consistent with the biannual Council on Long Range Planning and Development report. In addition, residents and fellows endorsed by their states to serve as sectional delegates and alternate delegates are included in the appropriate comparisons for the state and specialty societies. For the purposes of this report, AMA-HOD includes both delegates and alternate delegates.

DATA SOURCES

Lists of delegates and alternate delegates are maintained in the Office of House of Delegates Affairs and are based on official rosters provided by the relevant society. The lists used in this report reflect 2021 year-end delegation rosters.

Data on individual demographic characteristics are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all United States and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA membership and the total physician and medical student population are taken from the Masterfile and are based on 2021 year-end information.

Some key considerations must be kept in mind regarding the information captured in this report. Vacancies in delegation rosters mean that the total number of delegates is less than the 691 allotted at the November 2021 Special Meeting, and the number of alternate delegates is nearly always less than the full allotment. As such, the total number of delegates and alternate delegates is 1,126 rather than the 1,382 allotted. Race and ethnicity information, which is provided directly by physicians, is missing for approximately 25% of AMA members and approximately 23% of the total United States physician and medical student population, limiting the ability to draw firm conclusions. Efforts to improve AMA data on race and ethnicity are part of Policy D-630.972. Improvements have been made in collecting data on race and ethnicity, resulting in a decline in reporting race/ethnicity as unknown in the HOD and the overall AMA membership.

CHARACTERISTICS OF AMA MEMBERSHIP AND DELEGATES

Table 1 presents basic demographic characteristics of AMA membership and delegates along with corresponding figures for the entire physician and medical student population.

Data on physicians’ and students’ current activities appear in Table 2. This includes life stage as well as present employment and self-designated specialty.

Table 1. Basic Demographic Characteristics of AMA Members & Delegates, December 2021

2021	AMA Members	All Physicians and Medical Students	AMA Delegates & Alternate Delegates 1,2
Total	277,823	1,419,190	1,126
Mean age (years) ³	47	53	55
Age distribution (percent)			
Under age 40	50.03%	27.31%	18.56%
40-49 years	11.24%	17.95%	15.72%
50-59 years	9.86%	16.77%	18.65%
60-69 years	10.05%	16.67%	27.89%
70 or more	18.82%	21.30%	19.18%
Gender (percent)			
Male	60.60%	63.25%	64.56%
Female	38.55%	36.02%	35.35%
Unknown	0.85%	0.72%	0.09%
Race/ethnicity (percent)			
Asian	14.79%	15.39%	13.50%
Black or African American	4.89%	4.33%	5.15%
Hispanic, Latino, or Spanish Origin	5.94%	5.70%	3.46%
Native American	0.34%	0.27%	0.27%
Other	1.36%	1.43%	1.51%
Unknown	24.79%	23.46%	11.10%
White	47.89%	49.41%	65.01%
Education (percent)			
US or Canada	82.20%	77.67%	92.18%
IMG	17.80%	22.33%	7.82%

1. There were 256 vacancies as of year's end, 18 of which were delegates and the remainder being unfilled alternate delegate slots.
2. Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
3. Age as of December 31. Mean age is the arithmetic average.
4. Includes other self-reported racial and ethnic groups.

Table 2. Life Stage, Present Employment and Self-Designated Specialty⁵, December 2021

2021	AMA Members	All Physicians and Medical Students	AMA Delegates & Alternate Delegates 1,2
Life Stage (percent)			
Student ⁶	20.10%	7.79%	6.66%
Resident ⁶	25.66%	9.88%	6.75%
Young (under 40 or first 8 years in practice)	8.61%	13.71%	7.37%
Established (40-64)	21.78%	38.91%	44.23%
Senior (65+)	23.86%	29.71%	34.99%
Present Employment (percent)			
Self-employed solo practice	6.42%	7.94%	11.19%
Two physician practice	1.36%	1.77%	2.13%
Group practice	23.65%	39.55%	38.72%
HMO	0.24%	0.16%	0.89%
Medical school	0.94%	1.45%	3.20%
Non-government hospital	3.30%	4.84%	6.84%
State or local government hospital	3.79%	6.23%	10.39%
US government	0.87%	1.64%	3.29%
Locum Tenens	0.14%	0.19%	0.18%
Retired/Inactive	11.42%	12.42%	7.19%
Resident/Intern/Fellow	25.66%	9.88%	6.75%
Student	20.10%	7.79%	6.66%
Other/Unknown	2.12%	6.13%	2.58%
specialty (percent)			
Family Medicine	8.52%	11.34%	10.57%
Internal Medicine	19.49%	22.58%	20.78%
Surgery	13.18%	13.32%	19.72%
Pediatrics	5.09%	8.69%	4.09%
OB/GYN	4.83%	4.57%	6.84%
Radiology	3.32%	4.40%	5.33%
Psychiatry	4.19%	5.16%	4.26%
Anesthesiology	3.82%	4.93%	4.00%
Pathology	1.67%	2.19%	2.58%
Other specialty	15.78%	15.04%	15.19%
Students	20.10%	7.79%	6.66%

5. See Appendix for a listing of specialty classifications.

6. Students and residents are categorized without regard to age.

APPENDIX - Specialty Classification Using Physicians' Self-Designated Specialties.

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology

Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

20. DELEGATE APPORTIONMENT AND PENDING MEMBERS

Reference committee hearing: see report of Reference Committee F.

**HOD ACTION: RECOMMENDATION 3 ADOPTED
IN LIEU OF RESOLUTION 618
RECOMMENDATION 1 REFERRED FOR DECISION
RECOMMENDATIONS 2, 4, 5, AND 6 REFERRED
REMAINDER OF REPORT FILED**
See Policy G-600.959

At the 2018 Interim Meeting, policy was adopted calling for the inclusion of pending members in the delegate apportionment process. Per Board of Trustees Report 1-I-18 pending members are those who at the time they apply for AMA membership are not current in their dues and who pay dues for the following calendar year. The policy was refined in Board of Trustees Report 12-A-19 to address issues related to counting such members as well as distinctions between constituent and specialty societies, and the necessary bylaws amendments were adopted at the 2019 Interim Meeting (Council on Constitution and Bylaws Report 3-I-19). The policy, G-600.016, “Data Used to Apportion Delegates,” calls for an evaluation at this meeting of the House of Delegates.

Pending members were first included in the delegate apportionment process for the 2020 calendar year when they numbered 19,588. Nearly half came from a single large multispecialty, multisite group practice in California, and California gained ten additional delegates for 2020. Only one other state had more than 1000 pending members, and overall, the inclusion of pending members added 17 delegates from constituent societies to the House; an additional 17 came from specialty societies.

Counting pending members the first year proved an easy task, as the group was comprised of nonmembers in 2019. The membership accounting system does not, however, include the data elements necessary to distinguish among members who simply pay their dues early (ie, before the year ends), the prior year’s pending members who *must* pay their dues early in order to be counted for apportionment purposes, and new pending members (ie, current nonmembers joining for the following year). This means, for example, physicians who paid their 2022 dues in the last quarter of 2021 are treated as pending 2022 members. They may also have been actual members in 2021, but the timing of their dues payments makes them pending members for 2022, and in fact a longtime member who always pays dues in, say December, is effectively a pending member for apportionment purposes.

This shortcoming, though an annoyance, does not affect membership figures and the resulting delegate apportionment when pending members are included. The net effect is to inflate the number of pending members (with the corresponding number of “regular” members deflated). This situation was described in the apportionment memoranda that were distributed to societies in February. AMA’s official membership figures, which are based on the calendar year, are not affected.

CURRENT SITUATION

The secular increase in our AMA's membership has continued, now for over a decade, and 2021 ended with 277,823 active members. The apportionment membership number, however, was considerably smaller, because of the anomalous nature of counting pending members. As outlined in the apportionment memoranda earlier this year, the timing of a member's payment affects whether that individual is counted for apportionment purposes. The pending member whose dues are received in Year 1 to become a member in Year 2 but whose dues for Year 3 are received after January 1 of Year 3 cannot be counted for apportionment purposes under the bylaws regarding pending members and apportionment. The following chart may be clearer:

<u>Year</u>	<u>Dues received</u>	<u>Member year</u>	<u>In apportionment?</u>
Year 1	4 th quarter	Year 2	Yes, pending member, counted for Year 2
Year 2	not received	Year 2	Not counted, dues not received
Year 3	1st quarter	Year 3	Yes, regular member, counted at year-end

The apparent decline in membership using apportionment data is entirely due this phenomenon.

At the same time, the current freeze on delegations for constituent societies has meant that no state has lost delegates. The number of constituent society delegates has been stable for the three years 2020, 2021, and now 2022, with 304 delegates. (Pennsylvania lost one delegate before the freeze took effect, so 305 delegate seats were apportioned to states in 2020.) Because the overall number of constituent society delegates determines the number of specialty society delegates the total size of the House has also been stable, although another section was added in 2021.

Historical data on AMA membership, including the figures used for apportioning delegates is provided in the table below.

Year [†]	Official membership	year-end Apportionment membership [‡]	Pending members*
2010	215,854		
2011	217,490		
2012	224,503		
2013	227,874		
2014	232,126		
2015	234,360		
2016	240,498		
2017	243,449		
2018	250,253		
2019	256,364	275,956	19,588
2020	271,655	253,389	85,794
2021	277,823	238,800	83,077

[†] Year-end figures were used to apportion delegates through 2019.

[‡] Until year-end 2019 (for 2020 apportionment) actual membership was used for apportionment; starting with 2020, "apportionment member" figures were used.

* Pending members included in the apportionment membership figure.

IMPACT OF PENDING MEMBERS ON APPORTIONMENT

Disentangling the effects of counting pending members from other factors such as the current freeze on constituent society delegations or the year-to-year fluctuation in individuals' membership choices is not possible. The inclusion of pending members had a clear impact initially, when 34 delegate seats were added in the House, though as noted more than half of that total increase was attributed to a single entity. (The California increase doubled to maintain specialty society parity.) Since that initial round, tallying pending members has had no obvious impact, meaning the increase was essentially a one-time occurrence. This is so because at the end of 2019 pending members augmented the usual apportionment pool of active members. In the second and third years of this experiment, the number of pending members each year has been offset by the loss of members choosing not to renew their memberships. In essence, the group referred to as pending members comes from the same population that drops memberships. That is,

these are physicians or students whose allegiance to or participation in the AMA varies over time, depending on factors such as current finances, recent advocacy matters, or even just whims. Add the timing of membership processing—before or after January 1—and the effect of including pending members in delegate apportionment is minimal, and possibly negative, after the first year.

Surveys have for many years found that AMA advocacy is the most sought after and valued benefit of AMA membership. Aside from a handful of members who are seeking to become delegates, the notion that counting pending members for apportionment purposes will benefit physicians simply does not square with what members report. As a practical matter, benefits from our AMA’s advocacy activities arguably accrue to all physicians, not just members, so the pending members gain little from that status. The onetime increase in delegation sizes combined with the complications of membership accounting do not warrant continuing the experiment. Rather a return to the historical practice of counting actual members for apportionment purposes—a practice that likely antedates the decision of all members of the House to become physicians—seems warranted.*

AFTER THE EXPERIMENT

Somewhat counterintuitively, absent the current freeze, counting pending members may have negatively affected nearly as many states as it helped, and while several states did gain delegates with the inclusion of pending members, only three states gained more than one delegate: two states gained two seats and one state gained 10 seats.

Worth noting is the fact that the effect of the delegate freeze would have been limited for the 2021 and 2022 apportionment years had the usual year-end count of AMA members been employed. The freeze was implemented based on fears that COVID-19 would adversely affect AMA membership and was adopted pursuant to Resolution 8-N-20, but AMA membership is up over the last two years, to 277,823 at the end of 2021 from 256,364 two years earlier.

Using year-end 2021 actual membership figures—meaning pending members are not included in the calculations—constituent societies would send 303 delegates to the House this year, versus 304 with pending members. That number is calculated at the usual 1 per 1000, or fraction thereof, AMA members “within the jurisdiction of each constituent association” (Bylaws §2.1.1) and does not consider any other bylaws provisions such as §2.1.1.2.1, which provides an opportunity for a constituent society to at least delay the loss by filing a “written plan of intensified AMA membership development activities among its members,” thus affording the society time to recover. Should AMA membership experience a year over year decline at some point, the bylaws offer protections for the affected societies.

The unique circumstances created by the confluence of the SARS-CoV-2 pandemic, the experiment with pending members, and the current delegate freeze call for a tailored return to the use of actual year-end membership for apportioning delegates. As noted, the bylaws allow constituent societies to delay and possibly eliminate the loss of delegate positions. Your Board believes that the following mechanism to return to counting only actual members will protect societies and minimize disruptions in delegate selection for societies.

- Delegate apportionment for constituent societies in 2023 will be based on year-end actual AMA membership figures.
- In 2023, constituent societies will have the greatest of 1) the number of delegates apportioned on the basis of 1 per 1000, or fraction thereof, AMA members, which is the standard apportionment; or 2) the number of delegates apportioned for 2022 if that figure is no more than 2 greater than the standard apportionment; or 3) where the standard apportionment would subject the society to a loss of more than 5 delegates over 2022, the number of delegates apportioned in 2022 plus 5.
- In 2024, delegates will be apportioned to constituent societies according to then current bylaws.
- All other entities seated or to be seated in the House will continue to be subject to the relevant bylaws.

* In fact a delegate would have to turn 72 this year to have even been alive when the policy to count active AMA members for delegate apportionment was adopted. Last year, the average age of delegates was not quite 57. (See CLRPD’s June 2021 demographic report or Board Report 19 at this meeting.)

RECOMMENDATIONS

Your Board of Trustees recommends that the following recommendations be adopted and the remainder of the report be filed.

[Editor's note: The following Recommendation 3 was adopted in lieu of Resolution 618.]

3. That delegates be apportioned to constituent societies for 2023 with each society getting the greatest of the following numbers:
 The number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members;
 The number of delegates apportioned for 2022 so long as that figure is not greater than 2 more than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA members; or
 For societies that would lose more than five delegates from their 2022 apportionment, the number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members plus 5.

[Editor's note: Recommendation 1 referred for decision; Recommendations 2, 4, 5, and 6 referred.]

1. That pending members no longer be considered in apportioning delegates in the House of Delegates.
2. That delegate apportionment for 2023 for constituent societies be based on official 2022 year-end AMA membership data as recorded by the AMA.
4. That delegate apportionment for 2024 be based on then current bylaws. (Directive to Take Action)
5. That the Council on Constitution and Bylaws prepare bylaws amendments to implement these recommendations, with the report to be considered no later than the November 2022 meeting of the House of Delegates.
6. That Policy G-600.016, "Data Used to Apportion Delegates," be rescinded.

21. OPPOSITION TO REQUIREMENTS FOR GENDER-BASED TREATMENTS FOR ATHLETES (RESOLUTION 19-A-19)

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

HOD ACTION: REFERRED

Resolution 19-A-19, "Opposition to Requirements for Gender-Based Treatment for Athletes," sponsored by the Medical Student Section, was referred to the Board of Trustees. The resolution asked:

1. That our American Medical Association (AMA) oppose any regulations requiring mandatory medical treatment or surgery for athletes with Differences of Sex Development (DSD) to be allowed to compete in alignment with their identity; and
2. That our AMA oppose the creation of distinct hormonal guidelines to determine gender classification for athletic competitions.

BACKGROUND

Resolution 19 reacts to guidelines issued in 2018 by the International Association of Athletics Federations (IAAF)—now World Athletics—updating eligibility criteria for athletes with differences of sex development (DSD) who wish to compete as women in certain international track and field events. Under these guidelines, to be eligible to compete in the 400 meters, hurdles races, 800m, 1500m, one-mile races and combined events over the same distances, women with DSD who have serum testosterone levels above 5 nmol/L and who are androgen sensitive must:

- be legally recognized as female or intersex
- reduce their circulating serum testosterone levels to below 5 nmol/L for a continuous period of 6 months, and

- maintain their serum testosterone level below 5 nmol/L continuously for as long as they wish to remain eligible to compete (regardless of whether they are in competition) [1]

Female athletes with DSD who choose not to reduce their serum testosterone levels will be eligible to compete in all events that are not international competitions and in events in international competitions other than those specifically prohibited [1].

These guidelines represent the most recent in a series of efforts by the international athletic community to ensure fairness in women's competitions that began with "gender verification" policies in the 1960s. In 1968, following the extraordinary successes of Tamara and Irina Press, who were suspected of being male, in the 1960 and 1964 Olympics, female athletes were required to prove their sex to be eligible to compete as women in international events [2].

Over time, procedures to determine sex evolved from having female athletes parade naked before a panel of judges, through gynecological examination of external genitalia, to the use of sex chromatin tests, and ultimately DNA-based testing [2]. In 2000, the International Olympic Committee (IOC) and IAAF discontinued routine gender verification in favor of "suspicion-based testing," reserving the right to test if officials or competitors raised questions about a female athlete's sex.

In 2011, in the wake of controversy over South African runner Caster Semenya, the IOC's Medical Commission recommended hormone-based testing, that is, that individuals recognized in law as female be eligible to compete in women's competitions so long as their serum testosterone levels were "below the male range" or if they had an androgen resistance and derived no competitive advantage from testosterone levels in the male range [2]. The IAAF adopted hormonal testing and implemented new policy that routinely tested all female athletes and required those who tested outside the normal range to undergo treatment to normalize their androgen levels to be eligible to compete.

In March 2019 the United Nations Council on Human Rights adopted Resolution 40/5, "Elimination of discrimination against women and girls in sport," noting concern that the IAAF/World Athletics eligibility criteria

are not compatible with international human rights norms and standards, including the rights of women with differences of sex development, and concerned at the absence of legitimate and justifiable evidence for the regulations to the extent that they may not be reasonable and objective, and that there is no clear relationship of proportionality between the aim of the regulations and the proposed measures and their impact [3].

The resolution further expressed concern that

discriminatory regulations, rules and practices that may require women and girl athletes with differences of sex development, androgen sensitivity and levels of testosterone to medically reduce their blood testosterone levels contravene international human rights norms and standards ... [3]

In 2021, following ongoing controversy, the IOC amended its stance and issued a new "Framework on Fairness, Inclusion and Non-Discrimination on the Basis of Gender Identity and Sex Variations" that eliminated specific instructions on eligibility to compete [4]. Rather, the framework sought to offer general guidance to sports governing bodies

to promote a safe and welcoming environment for everyone, consistent with the principles enshrined in the Olympic Charter," and "acknowledges the central role that eligibility criteria play in ensuring fairness, particularly in high-level organized sport in the women's category" [4].

With the framework, the IOC recognized "that it is not in a position to issue regulations that define eligibility for every sport" and explicitly left it "to each sport and its governing body to determine how an athlete may be at disproportionate advantage to their peers" [4].

Also in 2021, the authors of a 2017 study on which World Athletics relied heavily in developing its eligibility criteria published a correction in response to ongoing critique from independent statisticians. The correction acknowledged that "there is no confirmatory evidence for causality in the observed relationships reported" [5]. The authors further noted that the initial research was "exploratory and not intend[ed] to prove a causal influence" and that "some statements in the original publication "could have been misleading" [5].

World Athletics has not modified its criteria [5], however, and controversy regarding participation by female athletes with DSD continues.¹

FAIRNESS IN SPORT

Regulations intended to promote fairness in sport by restricting the participation of individuals whose genetic characteristics are deemed to give them unfair advantage over competitors raise a series of questions about what the goals of sport are, what counts as an “unfair” advantage, and what should be done to “level the playing field.”

Biological Advantage

Policy restricting competition by female athletes who have serum testosterone levels above a designated “normal” range rests on (at least) two problematic assumptions. The first of those assumptions is that there is a straightforward relationship between testosterone and athletic performance that unequivocally gives these athletes significant advantage over female competitors whose bodies do not produce “excess” endogenous testosterone. The second is that serum testosterone levels can meaningfully be measured, and that prescribed levels can be safely and effectively maintained. The specific contribution of testosterone to overall athletic performance continues to be a subject of debate. Notably, critics of the research on which the IAAF based its regulations on endogenous testosterone have argued that a key study concluding that women with the highest testosterone levels significantly and consistently outperformed other female competitors rests on flawed data [6]. Concerns have also been raised about the rigor of its statistical analysis [7]. The main author, moreover, was the director for the IAAF Science and Health Department, raising questions about possible conflict of interest [8]. More important, however, demonstrating a correlation between testosterone and athletic performance in female athletes falls short of establishing the unfairness of such advantage [8].

However, even if the effect of testosterone on athletic performance was conclusively established specific to the restricted events identified by the IAAF, single point-in-time tests for overall level of serum testosterone cannot provide conclusive evidence that the individual has or will benefit. It is known that women with androgen insensitivity disorder physiologically cannot gain benefit from excess endogenous testosterone. Multiple factors affect serum concentrations of testosterone, including time of day; age- and gender-corrected normal ranges using a standard assay have not been established; and there is no universally recognized standard for calibrating testosterone [9].

Further, “the relevance of free testosterone vs [sic] the fraction actually available to tissues (the “bio-testosterone”) is not well understood” [10]. Nor do the IAAF regulations take into account the existing lack of consensus about “how to use medications safely to lower testosterone levels when used off-label, the side effects of the medications, [or] the difficulties of maintaining the testosterone levels below the levels requested by IAAF owing to natural fluctuations” [8].

Leveling the Playing Field

Assuming, for purposes of analysis, that testosterone does confer a significant competitive advantage in sport, knowing that does not in itself determine what steps should be taken to “level the playing field.” The latter decision is a normative matter, not an empirical one.

To be defensible, rules and practices intended to ensure that no individual athlete enjoys an unfair advantage over competitors require that rules treat all relevantly similar advantage-conferring attributes in a like manner for all prospective competitors. Testosterone testing for female athletes who have been singled out on the basis of their appearance or performance for all practical purposes subjects these individuals to genetic testing not imposed on their competitors.

Fairness would thus require that sports organizations test for any “performance enhancing genes that predispose [individual athletes] to be athletically superior” [11]. In the present state of knowledge, this is no more realistic an

¹ Analogous controversy continues with respect to sports participation by transgender women at all levels of competition. For an exploration of issues in this context in relation to the IOC framework, see Harper J. Transgender athletics and international sports policy. *Law and Contemporary Problems* 2022;85:151-165. Available at <https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=5035&context=lcp>. Accessed March 23, 2022.

approach than are current testosterone assays. The influence of genetic factors on athletic performance is multifactorial and sport specific [12]. Organizations would further have to regulate all such advantage-conferring attributes consistently.

One way to categorize fair versus unfair advantages is by conceptualizing advantages as stable or dynamic [13]. Fair advantages are those the athlete largely cannot affect (such as chronological age, height, genetics, etc.). Unfair advantages are those the athlete can affect (such as speed, strength, endurance, etc.). On this account, genetic differences in testosterone would be stable advantages that could be subject to leveling or more fine-grained classification.

Thinking specifically about leveling the playing field with respect to genetically based inequalities in endogenous testosterone, three approaches present themselves [8]. First, sports organizations could require athletes to lower testosterone levels that exceed a defined threshold. Sports organizations could require that athletes with testosterone levels that exceed a defined threshold lower them to below a predetermined level.

As a second approach, organizations could create separate categories for competition based on the level of biological variations, allowing all athletes with serum testosterone within a certain range to compete against one another, regardless of sex or gender identification [8]. Or, third, they could create categories based on modifying the external conditions of competition instead of intervening in athletes' bodies. Handicapped horse racing offers a model [8].

THE ROLE OF PHYSICIANS

World Athletics eligibility criteria take the first of these approaches: intervening in the bodies of athletes. In doing so, they virtually require the participation of physicians helping athletes achieve and maintain the stipulated levels of serum testosterone. To the extent that medical interventions to lower testosterone are not *clinically* indicated, is physician participation appropriate? Overall, existing policies of the American Medical Association and the World Medical Association (WMA) argue against physicians implementing these regulations.

Existing AMA policy in H-470.978, "[Blood Doping](#)," and H-470.976, "[Abuse of Anabolic Steroids](#)," prohibit physician participation in blood doping or prescribing anabolic steroids. H-470.994, "[Non-Therapeutic Use of Pharmacological Agents by Athletes](#)," opposes the use of interventions to enhance athletic performance but is silent with respect to physicians' specific responsibilities.

[Principle VIII](#) of the AMA *Principles of Medical Ethics* states that "A physician shall, while caring for a patient, regard responsibility to the patient as paramount." Opinion 1.2.5, "[Sports Medicine](#)," in the AMA *Code of Medical Ethics* limits its focus to physicians present during athletic events. It directs those who "serve in a medical capacity at athletic, sporting, or other physically demanding events should protect the health and safety of participants." Opinion 5.5, "[Medically Ineffective Interventions](#)," which specifically addresses the use of life-sustaining interventions in contexts of terminal illness, provides that physicians "should only recommend and provide interventions that are medically appropriate." It notes further that patients should not receive specific interventions simply because they request them.

In a press release in April 2019, the [World Medical Association](#) demanded that the IAAF "immediately withdraw" its new eligibility regulations for classifying female athletes and urged physicians to "take no part" in implementing them. In October 2021 WMA updated "[Declaration on Principles of Health Care in Sports Medicine](#)" to oppose World Athletics eligibility regulations and condemn "medical treatment solely to alter athletic performance," as "unethical."

These provide several strong arguments, that, as professionals committed to promoting first and foremost the well-being of their patients, it is not appropriate for physicians to provide medical interventions for athletes required to fulfill the World Athletics regulations on endogenous testosterone for female athletes with differences of sexual development.

RECOMMENDATION

In view of these considerations, your Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 19-A-19 and the remainder of this report be filed:

1. That our American Medical Association (AMA) oppose mandatory medical treatment or surgery for athletes with Differences of Sex Development (DSD) to be allowed to compete in alignment with their identity.
2. That our AMA oppose use of specific hormonal guidelines to determine gender classification for athletic competitions.

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22. NONCONSENSUAL AUDIO/VIDEO RECORDING AT MEDICAL ENCOUNTERS (RESOLUTION 7-JUN-21)

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

**HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED**
See Policy H-315.983

Resolution 007-June-21, “Nonconsensual Audio/Video Recording at Medical Encounters,” sponsored by the Virginia, New Jersey, District of Columbia, and Maryland Delegations along with the America Association of Clinical Urologists and the American Urological Association, was referred by the House of Delegates. Resolution 007 asks our AMA to:

[E]ncourage that any audio or video recording made during a medical encounter should require both physician and patient notification and consent.

NONCONSENSUAL RECORDING AND STATE RECORDING LAWS

Recording patient-physician encounters without the consent of one of the parties is of long-standing concern both ethically and legally and such nonconsensual recording has received increased attention in recent years. New

technology—such as smartphones—has made recordings easier and “more commonplace” [1]. Recording an interaction with their physician can offer benefits for patients. For example, it can provide a convenient way to recall and better understand their information or to share information more accurately with caregivers [2]. However, from the physician’s perspective recordings also raise concerns “about the ownership of recordings and the potential for these to be used as a basis for legal claims or complaints” [1]. Hence, many physicians worry that covert recordings could breach trust and harm the patient-physician relationship and have looked to the law for protection. Laws in the United States regarding recordings are “complex” and “vary at the state level” [1]. Some state laws require only one party to a conversation to give consent to record a conversation, while some require all parties to consent [1]. “All parties” jurisdictions are in the minority: only 11 states require all parties to a conversation consent to recording in order for such recording to be lawful [3].

The use of virtual medical scribes, who are not physically present with the patient and physician, creates a context in which similar concerns may arise since scribes have remote audio or audiovisual access to the patient-physician interaction [4,5]. There is a relative paucity of data regarding patient perceptions or concerns in this area, but little to suggest that patients object to or are distrustful of virtual scribes [6], despite early concerns [7], as long as they are aware their visit is being observed or recorded remotely. Physicians are not uniformly required to notify patients that they use virtual scribes or obtain patient consent, but patient advocacy organizations encourage patients to discuss privacy concerns with their physician [8]. Guidelines established by the Joint Commission in 2011 require that virtual scribes employed by JC-accredited entities “meet all requirements of information management, HIPAA, HITECH, confidentiality and patient rights standards just as any other hospital personnel” [9]. Emerging augmented intelligence (AI) enabled scribe services (“digital scribes”) that utilize deep learning protocols and natural language processing to capture information for the medical record raise similar concerns, and are subject to similar responsibilities with respect to the security and confidentiality of personal health information [10].

AMA HOUSE POLICY AND ADVOCACY EFFORTS

At its 2018 meeting, the House of Delegates adopted Resolution 232-A-18, “Recording Law Reform,” which called on AMA to “draft model state legislation requiring consent of all parties to the recording of a patient-physician conversation.” Resolution 232, sponsored by the Oklahoma Delegation, noted in its rationale that “[r]ecording in a public part of a doctor’s office could violate other patients’ privacy while making a recording in secret could both lead to a fundamental breach in the trust relationship between the health professional and the patient.”

This resolution was implemented by amending existing AMA Policy [H-315.983](#), “Patient Privacy and Confidentiality,” to incorporate the language adopted by the HOD as a new provision of policy. In 2019, AMA Advocacy staff prepared model legislation in the “Patient-Physician Encounter Recording Reform Act,” which mandates consent of all parties to any recording of a communication between a physician and patient [Appendix I]. The model act states that it shall be unlawful for a person to:

1. Obtain or attempt to obtain the whole or any part of a conversation, telecommunication, or other oral communication between a physician and patient by means of any device, contrivance, machine or apparatus, whether electrical, mechanical, manual or otherwise, if:
 - a. a patient-physician relationship has been established between the patient and physician, and
 - b. not all participants in the conversation have given consent to being recorded.

AMA ETHICS POLICY

The AMA *Code of Medical Ethics* provides guidance on recording patient-physician interactions in two specific contexts: for purposes of educating health care professionals ([Opinion 3.1.3](#), “Audio or Visual Recording Patients for Education in Health Care”) and for purposes of public education ([Opinion E-3.1.4](#), “Audio or Visual Recording of Patients for Public Education”). This guidance notes that in neither case is recording intended to benefit the patient and underscores the importance of protecting patient privacy and of obtaining informed consent from the patient (or surrogate) for any recording. Guidance further observes that recording creates a permanent record of personal patient information and may in some instances be considered part of the medical record and subject to laws governing medical records.

Guidance elsewhere in the *Code* emphasizes the importance of trust in patient-physician relationships and the need for candor between patient and physician ([Opinions 1.1.1](#), “Patient-Physician Relationship,” and [1.1.4](#), “Patient Responsibilities,” respectively).

CONCLUSION

Like Resolution 232-A-18, Resolution 7-June-21 seeks to address concern that recording patient-physician interactions, while potentially beneficial, also carries risks and may undermine the trust essential to patient-physician relationships. They share the conviction that all parties should be aware when recording is taking place and should consent to being recorded. Existing policy in [H-315.983](#) and guidance in the *Code of Medical Ethics* address these issues and fulfill the intent of Resolution 7-June-21.

RECOMMENDATION

In consideration of the foregoing, your Board of Trustees recommends that Policy H-315.983, “Patient Privacy and Confidentiality,” be reaffirmed in lieu of Resolution 7-June-21 and the remainder of this report be filed.

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APPENDIX

IN THE GENERAL ASSEMBLY STATE OF _____

Patient-Physician Encounter Recording Reform Act

Be it enacted by the People of the State of _____, represented in the General Assembly:

Section 1. Title. This act shall be known as and may be cited as the “Patient-Physician Encounter Recording Reform” Act.

Section 2. Purpose. The Legislature hereby finds and declares that:

1. 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;
2. The relationship that arises between a patient and a physician is based on trust, and is intimate and sacred;
3. Physicians have an ethical obligation under the AMA Code of Medical Ethics to inform the patient about audio or visual recording of the patient and obtain consent prior to the recording;
4. Patients have no such obligation to obtain consent from the physician prior to recording;
5. Secret recordings of physician encounters by patients could lead to a fundamental breach in the trust relationship between the physician and the patient;
6. Open communication about a patient’s intent to record a conversation is essential to preserve trust.

Section 3. Prohibitions. Except as otherwise provided in [reference state wiretapping laws], it shall be unlawful for a person to:

1. Obtain or attempt to obtain the whole or any part of a conversation, telecommunication, or other oral communication between a physician and patient by means of any device, contrivance, machine or apparatus, whether electrical, mechanical, manual or otherwise, if
 - a. a patient-physician relationship has been established between the patient and physician, and

- b. not all participants in the conversation have given consent to being recorded;
- 2. Obtain the whole or any part of a conversation, telecommunication, or other oral communication between a physician and patient from any person, while knowing or having good reason to believe that the conversation, telecommunication or other oral communication was initially obtained in a manner prohibited by this section;
- 3. Use or attempt to use, or divulge to others, any conversation, telecommunication or other oral communication obtained by any means prohibited by this section.

Section 4. Remedies. Any person whose conversation, telecommunication or oral communication is intercepted, disclosed, or used in violation of Section 3 shall have a civil cause of action against any person who intercepts, discloses, or uses, or procures any other person to intercept, disclose or use such communications, to enjoin a violation of Section 3 and be entitled to recover from any such person:

- 1. actual damages; and
- 2. reasonable attorney's fees and other litigation costs reasonably incurred.

Section 5. Effective. This Act shall become effective immediately upon being enacted into law.

Section 6. Severability. If any provision of this Act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby declared severable.

23. 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 seated in the House of Delegates (HOD) scheduled to submit information and materials for the 2022 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," and AMA Bylaw 8.5, "Periodic Review Process."

Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of professional interest medical associations and national medical specialty organizations 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 2022 Annual Meeting:

Academy of Physicians in Clinical Research
 American Society for Reproductive Medicine
 American Society of General Surgeons
 American Society of Hematology
 American Society of Transplant Surgeons
 American Thoracic Society
 College of American Pathologists
 Congress of Neurological Surgeons
 Eye and Contact Lens Association
 International College of Surgeons – US Section
 International Society of Hair Restoration Surgery
 Society for Cardiovascular Angiography and Interventions
 Society for Investigative Dermatology
 United States and Canadian Academy of Pathology

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 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 by the Academy of Physicians in Clinical Research, American Society for Reproductive Medicine, American Thoracic Society, College of American Pathologists, Congress of Neurological Surgeons, International College of Surgeons – US Section, Society for Cardiovascular Angiography and Interventions, and the Society for Investigative Dermatology, indicate the organizations meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted by American Society of General Surgeons, American Society of Hematology, American Society of Transplant Surgeons, International Society of Hair Restoration Surgery and United States and Canadian Academy of Pathology, indicate the organizations did not meet all guidelines and are not in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The Eye and Contact Lens Association did not submit materials for the review but did submit a letter ending the organizations involvement with the AMA.

RECOMMENDATIONS

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

1. That the Academy of Physicians in Clinical Research, American Society for Reproductive Medicine, American Thoracic Society, College of American Pathologists, Congress of Neurological Surgeons, International College of Surgeons – US Section, Society for Cardiovascular Angiography and Interventions, and the Society for Investigative Dermatology, retain representation in the AMA House of Delegates.
2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5, the American Society of General Surgeons, American Society of Hematology, American Society of Transplant Surgeons, International Society of Hair Restoration Surgery and United States and Canadian Academy of Pathology be placed on probation and be given one-year to work with AMA membership staff to increase their AMA membership.
3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 the Eye and Contact Lens Association not retain representation in the House of Delegates.

APPENDIX

Exhibit A - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
Academy of Physicians in Clinical Research	146 of 413 (35%)
American Society for Reproductive Medicine	487 of 2,073 (23%)
American Society of General Surgeons	15 of 39 (38%)
American Society of Hematology	963 of 6,741 (14%)
American Society of Transplant Surgeons	138 of 799 (17%)
American Thoracic Society	1,304 of 7,205 (18%)
College of American Pathologists	2,887 of 14,297 (20%)
Congress of Neurological Surgeons	773 of 3,682 (20%)
Eye and Contact Lens Association	No Data
International College of Surgeons – US Section	169 of 488 (35%)
International Society of Hair Restoration Surgery	82 of 237 (35%)
Society for Cardiovascular Angiography and Interventions	745 of 3,240 (23%)
Society for Investigative Dermatology	226 of 785 (29%)
United States and Canadian Academy of Pathology	777 of 4,490 (17%)

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (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.

Exhibit C – AMA Bylaws on Responsibilities of National Medical Specialty Societies

- 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.

REPORT 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, and where necessary, editorial corrections will also be made (e.g., numbering corrections).

RECOMMENDED RECONCILIATIONS

Policies to be rescinded in part

- H-65.952, "Racism as a Public Health Threat"
 1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
 2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
 - ~~3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.~~
 4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
 5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
 6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Board of Trustees Report 6-N-21, "Mitigating the Effects of Racism in Health Care: 'Best Practices'," was prepared specifically in response to paragraph 3 of this policy and that part of the policy will be rescinded. As additional reports are forthcoming pursuant to this policy and other related policies (D-350.981, "Racial Essentialism in Medicine;" H-65.952, "Racism as a Public Health Threat;" and H-65.953, "Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice"), this portion of the policy has been fulfilled, and the four policies will allow additional reports addressing the matter as best practices are identified.

- D-600.956, "Increasing the Effectiveness of Online Reference Committee Testimony"
 1. Our AMA will conduct a trial of two-years during which all reference committees, prior to the in-person reference committee hearing, produce a preliminary reference committee document based on the written online testimony.

2. The preliminary reference committee document will be used to inform the discussion at the in-person reference committee.
3. There be an evaluation to determine if this procedure should continue.
4. ~~Our AMA will pursue any bylaw changes that might be necessary to allow this trial.~~
5. The period for online testimony will be no longer than 14 days.

Existing bylaws allow the House to direct such activities. See §2.13.1.5. This clause is therefore superfluous and will be rescinded.

Policies to have a change in title

- D-383.996 “Impact of the NLRB Ruling in the Boston Medical Center Case”
Our AMA: (1) representatives to the ACGME be encouraged to ask the ACGME to review the Institutional Requirements and make recommendations for revisions to address issues related to the potential for resident physicians to be members of labor organizations. This is particularly important as it relates to the section on Resident Support, Benefits, and Conditions of Employment; and (2) through the Division of Graduate Medical Education, the Resident and Fellow Section, and the Private Sector Advocacy Group develop a system to inform resident physicians, housestaff organizations, and employers regarding best practices in labor organizations and negotiations.

The title will be changed to “AMA Resources, Advocacy, and Leadership Efforts to Secure Labor Protections for Physicians in Training.”

This policy was reaffirmed at A-20, but the NLRB ruling is not descriptive of the policy, which has as its focus labor protections for physicians in training. In addition, AMA policy generally avoids reference to specific laws and regulations because they may change and no longer be relevant. This change was suggested by the Resident and Fellow Section.

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