AMA 175TH ANNIVERSARY 1847 · 2022

AMA HOUSE OF DELEGATES HANDBOOK

2022 Annual Meeting
Hyatt Regency Chicago / June 10–15

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

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LIST OF MATERIAL INCLUDED IN THIS HANDBOOK (A-22)

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

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

1. **Memorandum from the Speaker**

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

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

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

5. **Hotel Map**

6. **Official Call to the Officers and Members of the AMA**

7. **Note on Order of Business**

8. **Summary of Fiscal Notes**

9. **Listing of Resolutions (by sponsor)**

FOLLOWING COLLATED BY REFERRAL

10. Report(s) of the Board of Trustees - Bobby Mukkamala, MD, Chair

01 Annual Report (F)

02 New Specialty Organizations Representation in the House of Delegates (Amendments to C&B)

03 2021 Grants and Donations (Info. Report)

04 AMA 2023 Dues (F)

05 Update on Corporate Relationships (Info. Report)

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

07 AMA Performance, Activities and Status in 2021 (Info. Report)

08 Annual Update on Activities and Progress in Tobacco Control: March 2021 through February 2022 (Info. Report)

09 Council on Legislation Sunset Review of 2012 House Policies (B)

10 American Medical Association Center for Health Equity Annual Report (Info. Report)

11 Procedure for Altering the Size or Composition of Section Governing Councils (F)

12 Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent (Info. Report)

13 Use of Psychiatric Advance Directives (Amendments to C&B)

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

15 Addressing Public Health Disinformation (D)

16 Language Proficiency Data of Physicians in the AMA Masterfile (F)

17 Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession (B)

18 Addressing Inflammatory and Untruthful Online Ratings (G)

19 Demographic Report of the House of Delegates and AMA Membership (Info. Report)

20 Delegate Apportionment and Pending Members (F)

21 Opposition to Requirements for Gender-Based Treatments for Athletes (Amendments to C&B)

11. Report(s) of the Council on Constitution and Bylaws - Pino D. Colone, MD, Chair

01 Clarification to the Bylaws: Delegate Representation (Amendments to C&B)

12. Report(s) of the Council on Ethical and Judicial Affairs - Alexander M. Rosenau, MD, Chair

01 Short-Term Medical Service Trips (Amendments to C&B)

02 Amendment to Opinion 10.8, Collaborative Care (Amendments to C&B)

03 Amendment to E-9.3.2, Physician Responsibilities to Colleagues with Illness, Disability or Impairment (Amendments to C&B)

04 CEJA's Sunset Review of 2012 House Policies (Amendments to C&B)

05 Pandemic Ethics and the Duty of Care (D-130.960) (Info. Report)

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

13. Opinion(s) of the Council on Ethical and Judicial Affairs - Alexander M. Rosenau, MD, Chair

01 Amendment to E-1.1.6, Quality (Info. Report)

02 Amendment to E-1.2.11, Ethical Innovation in Medical Practice (Info. Report)

03 Amendment to E-11.1.2, Physician Stewardship of Health Care Resources (Info. Report)

04 Amendment to E-11.2.1, Professionalism in Health Care Systems (Info. Report)

14. Report(s) of the Council on Medical Education - Niranjan V. Rao, MD, Chair

01 Council on Medical Education Sunset Review of 2012 House Policies (C)

02 An Update on Continuing Board Certification (C)

03 Onsite and Subsidized Childcare for Medical Students, Residents and Fellows (C)

04 Protection of Terms Describing Physician Education and Practice (C)

05 Education, Training and Credentialing of Non-Physician Health Care Providers and Their Impact on Physician Education and Training (C)

06 Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows (C)

15. Report(s) of the Council on Medical Service - Asa C. Lockhart, MD, Chair

01 Council on Medical Service Sunset Review of 2012 House Policies (G)

02 Prospective Payment Model Best Practices for Independent Private Practice (G)

03 Preventing Coverage Losses After the Public Health Emergency Ends (A)

04 Parameters of Medicare Drug Price Negotiation (A)

05 Poverty-Level Wages and Health (G)

16. Report(s) of the Council on Science and Public Health - Alexander Ding, MD, Chair

01 Council on Science and Public Health Sunset Review of 2012 HOD Policies (D)

02 Transformation of Rural Community Public Health Systems (D)

03 Correcting Policy H-120.958 (E)

17. Joint Report(s)

CCB/CLRPD 01 Joint Council Sunset Review of 2012 House Policies (F)

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

01 Recommendations for Policy Reconciliation (Info. Report)

19. Resolutions

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

002 Opposition to Discriminatory Treatment of Haitian Asylum Seekers (Amendments to C&B)

003 Gender Equity and Female Physician Work Patterns During the Pandemic (Amendments to C&B)

004 Recognizing LGBTQ+ Individuals as Underrepresented in Medicine (Amendments to C&B)

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

006 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism (Amendments to C&B)

007 Equal Access for Adoption in the LGBTQ Community (Amendments to C&B)

008 Student-Centered Approaches for Reforming School Disciplinary Policies (Amendments to C&B)

009 Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent (Amendments to C&B)

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

011 Evaluating Scientific Journal Articles for Racial and Ethic Bias (Amendments to C&B)

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

013 Recognition of National Anti-Lynching Legislation as a Public Health Initiative (Amendments to C&B)

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

102 Bundling Physician Fees with Hospital Fees (A)

103 COBRA for College Students (A)

104 Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for Health Care Financing (A)

105 Health Insurance that Fairly Compensates Physicians (A)

106 Hospice Recertification for Non-Cancer Diagnosis (A)

107 Medicaid Tax Benefits (A)

108 Payment for Regadenoson (Lexiscan) (A)

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

110 Private Payor Payment Integrity (A)

111 Bundled Payments and Medically Necessary Care (A)

112 Support for Easy Enrollment Federal Legislation (A)

113 Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation (A)

114 Oral Healthcare IS Healthcare (A)

115 Support for Universal Internet Access (A)

116 Reimbursement of School-Based Health Centers (A)

117 Expanding Medicaid Transportation to Include Healthy Grocery Destinations (A)

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

119 Medicare Coverage of Dental, Vision and Hearing Services (A)

120 Expanding Coverage for and Access to Pulmonary Rehabilitation (A)

121 Increase Funding, Research and Education for Post-Intensive Care Syndrome (A)

122 Medicaid Expansion (A)

123 Advocating for All Payer Coverage of Cosmetic Treatment for Survivors of Domestic Abuse and Intimate Partner Violence (A)

124 To Require Insurance Companies Make the "Coverage Year" and the "Deductible Year" Simultaneous for Their Policies (A)

125 Education, Forewarning and Disclosure Regarding Consequences of Changing Medicare Plans (A)

201 The Impact of Midlevel Providers on Medical Education (B)

202 AMA Position on All Payer Database Creation (B)

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

204 Insurance Claims Data (B)

205 Insurers and Vertical Integration (B)

206 Medicare Advantage Plan Mandates (B)

207 Physician Tax Fairness (B)

208 Prohibit Ghost Guns (B)

209 Supporting Collection of Data on Medical Repatriation (B)

210 Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits (B)

211 Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program (B)

212 Medication for Opioid Use Disorder in Physician Health Programs (B)

213 Resentencing for Individuals Convicted of Marijuana-Based Offenses (B)

214 Eliminating Unfunded or Unproven Mandates and Regulations (B)

215 Transforming Professional Licensure to the 21st Century (B)

216 Advocating for the Elimination of Hepatitis C Treatment Restrictions (B)

217 Preserving the Practice of Medicine (B)

218 Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas (B)

219 Due Process and Independent Contractors (B)

220 Vital Nature of Board-Certified Physicians in Aerospace Medicine (B)

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

302 Resident and Fellow Access to Fertility Preservation (C)

303 Fatigue Mitigation Respite for Faculty and Residents (C)

304 Organizational Accountability to Resident and Fellow Trainees (C)

305 Reducing Overall Fees and Making Costs for Licensing Exam Fees, Application Fees, Etc., Equitable for IMGs (C)

306 Creating a More Accurate Accounting of Medical Education Financial Costs (C)

307 Parental Leave and Planning Resources for Medical Students (C)

308 University Land Grant Status in Medical School Admissions (C)

309 Decreasing Bias in Evaluations of Medical Student Performance (C)

310 Support for Standardized Interpreter Training (C)

311 Discontinue State Licensure Requirement for COMLEX Level 2 PE (C)

312 Reduce Financial Burden to Medical Students of Medical Licensure Examinations (C)

313 Decreasing Medical Student Debt and Increasing Transparency in Cost of Medical School Attendance (C)

314 Support for Institutional Policies for Personal Days for Undergraduate Medical Students (C)

315 Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program (C)

316 Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools (C)

317 Medical Student, Resident and Fellow Suicide Reporting (C)

401 Air Quality and the Protection of Citizen Health (D)

402 Support for Impairment Research (D)

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

404 Weapons in Correctional Healthcare Facilities (D)

405 Universal Childcare and Preschool (D)

406 COVID-19 Preventive Measures for Correctional Facilities: AMA Policy Position (D)

407 Study of Best Practices for Acute Care of Patients in the Custody of the Law (D)

408 Supporting Increased Research on Implementation of Nonviolent De-escalation Training and Mental Illness Awareness in Law Enforcement (D)

409 Increasing HPV Vaccination Rates in Rural Communities (D)

410 Increasing Education for School Staff to Recognize Prodromal Symptoms of Schizophrenia in Teens and Young Adults to Increase Early Intervention (D)

411 Anonymous Prescribing Option for Expedited Partner Therapy (D)

412 Advocating for the Amendment of Chronic Nuisance Ordinances (D)

413 Expansion on Comprehensive Sexual Health Education (D)

414 Improvement of Care and Resource Allocation for Homeless Persons in the Global Pandemic (D)

415 Creation of an Obesity Task Force (D)

416 School Resource Officer Violence De-Escalation Training and Certification (D)

417 Tobacco Control (D)

418 Lung Cancer Screening Awareness (D)

419 Advocating for the Utilization of Police and Mental Health Care Co-Response Teams for 911 Mental Health Emergency Calls (D)

501 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use (E)

502 Ensuring Correct Drug Dispensing (E)

503 Pharmacy Benefit Managers and Drug Shortages (E)

504 Scientific Studies Which Support Legislative Agendas (E)

505 CBD Oil Use and the Marketing of CBD Oil (E)

506 Drug Manufacturing Safety (E)

507 Federal Initiative to Treat Cannabis Dependence (E)

508 Supplemental Resources for Inflight Medical Kit (E)

509 Regulation and Control of Self-Service Labs (E)

510 Evidence-Based Deferral Periods for MSM Cornea and Tissue Donors (E)

511 Over the Counter (OTC) Hormonal Birth Control (E)

512 Scheduling and Banning the Sale of Tianeptine in the United States (E)

513 Education for Patients on Opiate Replacement Therapy (E)

514 Oppose Petition to the DEA and FDA on Gabapentin (E)

515 Reducing Polypharmacy as a Significant Contributor to Senior Morbidity (E)

601 Development of Resources on End-of-Life Care (F)
602 Report on the Preservation of Independent Medical Practice (F)
603 September 11th as a National Holiday (F)
604 UN International Radionuclide Therapy Day Recognition (F)
605 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis (F)
606 Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System (F)
607 AMA Urges Health and Life Insurers to Divest of Investments of Fossil Fuels (F)
608 Transparency of Resolution Fiscal Notes (F)
609 Surveillance Management System for Organized Medicine Policies and Reports (F)
610 Making AMA Meetings Accessible (F)
701 Appeals and Denial - CPT Codes for Fair Compensation (G)
702 Health System Consolidation (G)
703 Mandatory Reporting of All Antipsychotic Drug Use in Nursing Home Residents (G)
704 Employed Physician Contracts (G)
705 Fifteen Month Lab Standing Orders (G)
706 Government Imposed Volume Requirements for Credentialing (G)
707 Insurance Coverage for Scalp Cooling (Cold Cap) Therapy (G)
708 Physician Burnout is an OSHA Issue (G)
709 Physician Well-Being as an Indicator of Health System Quality (G)
710 Prior Authorization - CPT Codes for Fair Compensation (G)
711 Reducing Prior Authorization Burden (G)
712 The Quadruple Aim - Promoting Improvement in the Physician Experience of Providing Care (G)
713 Enforcement of Administrative Simplification Requirements (G)
714 Prior Authorization Reform for Specialty Medications (G)
715 Prior Authorization - CPT Codes for Fair Compensation (G)
716 Discharge Summary Reform (G)
717 Expanding the AMA's Study on the Economic Impact of COVID-19 (G)
718 Degradation of Medical Records (G)
719 System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access (G)
720 Mitigating the Negative Impact of Step Therapy Policies and Nonmedical Switching of Prescription Drugs on Patient Safety (G)
721 Amend AMA Policy H-215.981 Corporate Practice of Medicine (G)
722 Eliminating Claims Data for Measuring Physician and Hospital Quality (G)

MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

- **All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items to be considered by the House.**

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

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

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

AMA
AMERICAN MEDICAL ASSOCIATION

UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

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

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

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

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

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

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

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

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

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

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

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

Preamble

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

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

Declaration

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

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

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

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

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

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

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

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

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

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

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

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

Delegate/Alternate Delegate Job Description, Roles and Responsibilities

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

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

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

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

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

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

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CAPACITY CHART

Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Skyway Level (East Tower)										
SKYWAY MEETING ROOMS										
Skyway Foyer	27'9" x 21'4" x 9'	507	—	40	—	—	6	—	—	—
Skyway 260	23'3" x 43'1" x 9'	961	40	100	51	36	30	—	—	—
Skyway 272	23'3" x 41'2" x 9'	811	40	70	45	36	28	—	—	—

FLOOR PLAN

Note: Above setups are tables and chairs ONLY without space left for other equipment such as staging, AV, display tables, registration tables or coffee breaks.

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Lobby Level (East Tower)										
PLAZA BALLROOM	92'9" x 28'9" x 10'6"	2,652	140	250	200	159	60	70	72	—
Plaza A	39'3" x 28'9"' x 10'6"	1,128	60	130	70	63	24	30	32	—
Plaza B	53' x 28'9" x 10'6"	1,524	80	150	130	96	36	40	40	—
Plaza Patio	34'5" x 115'3" x 9"	1,925	—	—	—	—	—	—	—	—
Plaza Park	— x — x —	—	—	—	—	—	—	—	—	—

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FLOOR PLAN
Concourse Level (East Tower)

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FLOOR PLAN
Ballroom Level (East Tower)

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CAPACITY CHART

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Exhibit Level (East Tower)										
RIVERSIDE EXHIBIT HALL										
HALL	CEILING HEIGHT 12'	70,000	2,330	7,000	—	—	—	—	—	355
EAST	—	30,000	870	2,500	2,400	—	—	—	—	151
WEST	—	40,000	1,330	4,500	3,300	—	—	—	—	204
EAST DOCK (D, E, F)	—	3 Bays	—	—	—	—	—	—	—	—

FLOOR PLAN

Note: Above setups are tables and chairs ONLY without space left for other equipment such as staging, AV, display tables, registration tables or coffee breaks.

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CAPACITY CHART

Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Third Floor (West Tower)										
FOUNDERS SUITES										
Dusable	26'5" x 26'7" x 9'	677	40	60	50	27	28	18	30	—
Field	25'5" x 26'3" x 9'	688	40	60	50	27	28	18	30	—
McCormick	25'5" x 26'3" x 9'	688	40	60	50	27	28	18	30	—
Burnham	25'5" x 24' x 10'	688	40	60	50	27	28	18	30	—
Addams	22' x 24'10" x 9'	556	40	50	32	18	20	15	18	—
Wright	23'8" x 26'3" x 9'	628	40	60	40	24	24	18	24	—
Ogden	23'8" x 26'3" x 9'	628	40	60	40	24	24	18	24	—
Horner	23'8" x 26'3" x 9'	628	40	60	40	24	24	18	24	—
Founders Foyer	16' x 23'10" x 9'	446	—	—	—	—	8	—	—	—

FLOOR PLAN

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CAPACITY CHART

Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Skyway Level (West Tower)										
THE LIVING ROOM	—	—	—	—	—	—	—	—	—	—
GALLERY COLLECTION										
The Gallery Lounge 6	23' x 52'10"	1,206	—	—	—	—	—	—	—	—
The Gallery Lounge 7	32'2" x 24'2"	759	—	—	—	—	—	—	—	—
Gallery 1 Boardroom	21'4" x 10'4"	223	—	—	—	—	10	—	—	—
Gallery 2 Boardroom	21'4" x 11'4"	251	—	—	—	—	10	—	—	—
Gallery 3 Boardroom	21'4" x 12'2"	258	—	—	—	—	10	—	—	—
Gallery 4 Boardroom	21'4" x 11'10"	284	—	—	—	—	10	—	—	—
Gallery 5	17'9" x 28'4"	470	20	40	30	24	18	—	—	—

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CAPACITY CHART

Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Lobby Level (West Tower)										
CRYSTAL BALLROOM	167' x 59' x 19'	9,853	700	1,000	950	500	—	—	—	40
Crystal A	43' x 59' x 19'	2,584	160	250	280	125	50	56	66	—
Crystal B	80' x 56' x 19'	4,559	320	500	450	240	100	70	82	—
Crystal C	43' x 59' x 19'	2,586	160	250	280	125	50	56	66	—
Crystal AB or BC	123' x 59' x 19'	7,198	480	750	870	380	120	129	150	—
CRYSTAL FOYER	—	5,120	—	400	—	—	—	—	—	—

FLOOR PLAN

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CAPACITY CHART

Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Concourse Level (West Tower)										
LANDMARK SUITES										
Comiskey	40' x 62' x 9'	1,982	70	200	90	84	40	36	42	—
Water Tower	45'3"' x 25' x 9'	1,143	80	120	120	54	28	26	36	—
Gold Coast	47'6" x 25' x 9'	1,178	80	120	120	54	28	26	36	—
Haymarket	29'6" x 19'6" x 9'	562	40	60	30	24	24	20	25	—
Picasso	29'6" x 22' x 9'	599	40	60	30	30	24	18	24	—
Columbian	27'3' x 25' x 9'	681	40	60	60	33	26	25	30	—
Soldier Field	34' x 25'8 x 9'	789	40	70	45	30	24	25	30	—
Wrigley	43' x 52' x 9'	1,540	70	140	60	48	30	25	30	—

FLOOR PLAN

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FLOOR PLAN
Ballroom Level (West Tower)

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CAPACITY CHART

Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Exhibit Level (West Tower)										
STETSON CONFERENCE CENTER										
Stetson Suite A	9' x 19' x 8'	378	10	25	24	15	12	—	—	—
Stetson Suite BC	30' x 17' x 8'	510	30	40	45	18	24	27	30	—
Stetson Suite D	18' x 24' x 8'	432	10	25	30	18	20	10	12	—
Stetson Suite E	30' x 27' x 8'	810	40	55	50	21	26	14	16	—
Stetson Suite F	36' x 25' x 8'	900	50	60	70	45	34	18	20	—
Stetson Suite G	36' x 14' x 8'	504	30	40	48	27	14	14	14	—
Stetson Suite F-G	36' x 39' x 8'	1,404	80	90	—	—	—	—	—	—

FLOOR PLAN

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2022 ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Official Call to the Officers and Members of the American Medical Association to attend the June 2022 Annual Meeting of the House of Delegates in Chicago, Illinois, June 10 - 15, 2022.

The House of Delegates will convene at 5:30 p.m., on June 10 at the Hyatt Regency Chicago.

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

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

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

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

Remaining eligible national medical specialty societies (63) are entitled to one delegate each.

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

State Medical Associations	306
National Medical Specialty Societies	304
Professional Interest Medical Associations	3
Other National Societies (AMWA, AOA, NMA)	3
Medical Student Regional Delegates	28
Resident and Fellow Delegate Representatives	33
Sections	11
Services	5
Total Delegates	**693**

Registration facilities will be maintained at the Hyatt Regency Chicago in the Grand Ballroom Foyer.

Gerald E. Harmon, MD
President

Bruce A. Scott, MD
Speaker, House of Delegates

Scott Ferguson, MD
Secretary

2021-2022

OFFICIALS OF THE ASSOCIATION

BOARD OF TRUSTEES (OFFICERS)

President - Gerald E. Harmon.....Pawleys Island, South Carolina
President-Elect -Jack Resneck..... San Rafael, California
Immediate Past President - Susan R. Bailey.....Fort Worth, Texas
Secretary - Scott Ferguson.....West Memphis, Arkansas
Speaker, House of Delegates - Bruce A. Scott ..... Louisville, Kentucky
Vice Speaker, House of Delegates - Lisa Bohman Egbert .....Kettering, Ohio

David H. Aizuss (2024)..... Encino, California
Madelyn E. Butler (2025)..... Tampa, Florida
Willarda V. Edwards (2024).....Baltimore, Maryland
Jesse M. Ehrenfeld (2022)..... Milwaukee, Wisconsin
Sandra Adamson Fryhofer (2022), *Chair-Elect*..... Atlanta, Georgia
Drayton Charles Harvey (2022).....Los Angeles, California
Pratistha Koirala (2023).....Danbury, Connecticut
Russell W.H. Kridel (2022).....Houston, Texas
Ilse R. Levin (2024) ..... Silver Spring, Maryland
Thomas J. Madejski (2024) .....Medina, New York
Mario E. Motta (2022) .....Salem, Massachusetts
Bobby Mukkamala (2025), *Chair*.....Flint, Michigan
Harris Pastides (2024) ..... Columbia, South Carolina
Michael Suk (2023) .....Danville, Pennsylvania
Willie Underwood, III (2023).....Buffalo, New York

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS
Pino D. Colone, Howell, Michigan, Chair (2024); Kevin C. Reilly, Sr., Elizabethtown, Kentucky, Vice-Chair (2022); Jerry P. Abraham, Los Angeles, California (2025); Patricia L. Austin, Alamo, California (2022); Mark N. Bair, Highland, Utah (2023); Mary Ann Contogiannis, Greensboro, North Carolina (2025); Christopher P. Libby, Anaheim, California (Resident) (2024); Michael J. Rigby, Madison, Wisconsin (Student) (2022).
Ex Officio, without vote: Bruce A. Scott, Louisville, Kentucky; Lisa Bohman Egbert, Kettering, Ohio.
Secretary: Janice Robertson, Chicago, Illinois.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
Alexander M. Rosenau, Allentown, Pennsylvania, Chair (2022); Peter A. Schwartz, Reading, Pennsylvania, Vice-Chair (2023); Rebecca W. Brendel, Boston, Massachusetts (2026); David A. Fleming, Columbia, Missouri (2024); Jeremy A. Lazarus, Greenwood Village, Colorado (2025); Kelsey Mumford, Austin, Texas (Student) (2023); Larry E. Reaves, Fort Worth, Texas (2027); Daniel P. Sulmasy, Washington, DC (2028); Danish M. Zaidi, Winston-Salem, NC (Resident) (2024).
Secretary: Elliott Crigger, Chicago, Illinois.

COUNCIL ON LEGISLATION
Mary S. Carpenter, Winner, South Dakota, Chair (2022); Heather Ann Smith, Newport, Rhode Island, Vice Chair (2022); Vijaya L. Appareddy, Chattanooga, Tennessee (2022); Molly Benoit, Miami, Florida (Student) 2022; Maryanne C. Bombaugh, Falmouth, Massachusetts (2022); Brooke M. Buckley, Bloomfield Hills, Michigan (AMPAC Liaison) (2022); Gary W. Floyd, Keller, Texas (2022); Merrilee Aynes Gober, Atlanta, Georgia (Alliance Rep) (2022); Ross F. Goldberg, Scottsdale, Arizona (2022); Marilyn J. Heine, Dresher, Pennsylvania (2022); Tripti C. Kataria, Chicago, Illinois (2022); Amar H. Kelkar, Gainesville, Florida (Resident) (2022); Ann Rosemarie Stroink, Bloomington, Illinois (2022); Marta J. Van Beek, Iowa City, Iowa (2022).
Secretary: George Cox, Washington, District of Columbia.

COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
Clarence P. Chou, Milwaukee, Wisconsin, Chair (2024); Edmond B. Cabbabe, St. Louis, Missouri, Vice Chair (2025); John H. Armstrong, Ocala, Florida (2025); Rijul Asri, Princeton, New Jersey (Student) (2022); Michelle A. Berger, Austin, Texas (2022); Jan M. Kief, Merritt Island, Florida (2023); G. Sealy Massingill, Fort Worth, Texas (2023); Benjamin D. Meyer, Seattle, Washington (Resident) (2022); Shannon Pryor, Chevy Chase, Maryland (2024); Gary D. Thal, Chicago, Illinois (2025).
Secretary: Susan Close, Chicago, Illinois.

COUNCIL ON MEDICAL EDUCATION
Niranjan V. Rao, Franklin Park, New Jersey, Chair (2022); John P. Williams, Gibsonia, Pennsylvania, Chair-Elect (2023); Sherri S. Baker, Edmond, Oklahoma (2025); Kelly J. Caverzagie, Omaha, Nebraska (2023); Sharon P. Douglas, Madison, Mississippi (2023); Louito C. Edje, Cincinnati, Ohio (2025); Robert B. Goldberg, Morristown, New Jersey (2025); Cynthia A. Jumper, Lubbock, Texas (2024); Rohan Khazanchi, Omaha, Nebraska (Student) (2022); Shannon M. Kilgore, Palo Alto, California (2023); David J. Savage, La Jolla, California (Resident) (2023); Krystal L. Tomei, Lyndhurst, Ohio (2025).
Secretary: Tanya Lopez, Chicago, Illinois.

COUNCIL ON MEDICAL SERVICE
Asa C. Lockhart, Tyler, Texas, Chair (2022); Lynn L. C. Jeffers, Camarillo, California, Chair-Elect (2024); Hussein A. Antar, Foxboro, Massachusetts (Student) (2022); Patrice Burgess, Boise, Idaho (2023); Alain A. Chaoui, Peabody, Massachusetts (2025); Steven L. Chen, San Diego, California (2024); Betty S. Chu, West Bloomfield, Michigan (2022); Alice Coombs, Richmond, Virginia (2023); Erick A. Eiting, New York, New York (2024); Stephen K. Epstein, Needham, Massachusetts (2022); Sheila Rege, Kennewick, Washington (2022); Megan L. Srinivas, Fort Dodge, Iowa (Resident) (2023).
Secretary: Val Carpenter, Chicago, Illinois.

COUNCIL ON SCIENCE AND PUBLIC HEALTH
Alexander Ding, Belmont, California, Chair (2024); Noel N. Deep, Antigo, Wisconsin, Chair-Elect (2023); Devin V. Bageac, Farmington, Connecticut (Student) (2022); John T. Carlo, Dallas, Texas (2025); Karen Dionesotes, Baltimore, Maryland (Resident) (2024); Kira A. Geraci-Ciardullo, Harrison, New York (2022); Mary E. LaPlante, Broadview Heights, Ohio (2025); Michael M. Miller, Madison, Wisconsin (2022); Tamaan K. Osbourne-Roberts, Denver, Colorado (2023); Padmini D. Ranasinghe, Baltimore, Maryland (2022); Corliss A. Varnum, Oswego, New York (2023); David J. Welsh, Batesville, Indiana (2024).
Secretary: Andrea Garcia, Chicago, Illinois.

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

EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

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

FORMER PRESIDENTS

David O. Barbe	2017-2018
Lonnie R. Bristow	1995-1996
Peter W. Carmel	2011-2012
Yank D. Coble, Jr.	2002-2003
Richard F. Corlin	2001-2002
Nancy W. Dickey	1998-1999
Andrew W. Gurman	2016-2017
Patrice A. Harris	2019-2020
J. Edward Hill	2005-2006
Ardis D. Hoven	2013-2014
Daniel H. Johnson, Jr.	1996-1997
Jeremy A. Lazarus	2012-2013
Robert E. McAfee	1994-1995
Barbara L. McAneny	2018-2019
Alan R. Nelson	1989-1990
John C. Nelson	2004-2005
Nancy H. Nielsen	2008-2009
Donald J. Palmisano	2003-2004
William G. Plested, III	2006-2007
Thomas R. Reardon	1999-2000
J. James Rohack	2009-2010
Randolph D. Smoak, Jr.	2000-2001
Steven J. Stack	2015-2016
Robert M. Wah	2014-2015
Cecil B. Wilson	2010-2011
Percy Wootton	1997-1998

FORMER TRUSTEES

Herman I. Abromowitz	1997-2005
Susan Hershberg Adelman	1998-2002
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Raj S. Ambay	2009-2011
Joseph P. Annis	2006-2014
Grayson W. Armstrong	2019-2021
John H. Armstrong	2002-2006
Maya A. Babu	2013-2017
Timothy E. Baldwin	1987-1989
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Regina M. Benjamin	1995-1998
Scott L. Bernstein	1991-1992
Stefano M. Bertozzi	1986-1988
David J. Brailer	1985-1986
Lonnie R. Bristow	1985-1994
Peter Carmel	2002-2010
Alice A. Chenault	1984-1985
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David S. Cockrum	1993-1994
MaryAnn Contogiannis	1989-1993
Malini Daniel	2012-2013
Christopher M. DeRienzo	2006-2008
Nancy W. Dickey	1989-1997
Alexander Ding	2011-2013
William A. Dolan	2007-2011
Timothy T. Flaherty	1994-2003
Melissa J. Garretson	1992-1993
Michael S. Goldrich	1993-1997
Julie K. Goonewardene	2012-2016
Andrew W. Gurman	2007-2015
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Hillary D. Johnson	2001-2002
Matthew D. Kagan	1999-2000
Christopher K. Kay	2008-2012
William E. Kobler	2012-2020
Edward L. Langston	2003-2011
Matthew C. Lawyer	2004-2005
Jeremy A. Lazarus	2005-2011
W. J. Lewis	1979-1984
Audrey J. Ludwig	1990-1991
Justin B. Mahida	2009-2010
Omar Z. Maniya	2016-2017
Robert E. McAfee	1984-1993
Barbara L. McAneny	2010-2017
William A. McDade	2016-2020
Mary Anne McCaffree	2008-2016
Joe T. McDonald	2005-2006
Samuel J. Mackenzie	2014-2015
Robert R. McMillan	2002-2008
Sandeep “Sunny” Mistry	2000-2001
Elizabeth Blake Murphy	2020-2021
Alan R. Nelson	1980-1988
John C. Nelson	1994-2003
Nancy H. Nielsen	2005-2007
Albert J. Osbahr, III	2011-2019
Donald J. Palmisano	1996-2002
Rebecca J. Patchin	1988-1989
Rebecca J. Patchin	2003-2011
Stephen R. Permut	2010-2018
Pamela Petersen-Crair	1996-1998
Dina Marie Pitta	2015-2016
William G. Plested, III	1998-2005
Stephen Pool	1995-1996
Liana Puscas	1999-2001
Thomas R. Reardon	1990-1998
Kevin C. Reilly	2003-2005
Ryan J. Ribeira	2013-2014
J. James Rohack	2001-2008
David A. Rosman	2002-2004
Samantha L. Rosman	2005-2009
Raymond Scalettar	1985-1994
Bruce A. Scott	1998-2002
Carl A. Sirio	2010-2018
Sarah Mae Smith	2019-2020
Randolph D. Smoak, Jr.	1992-1999
Steven J. Stack	2006-2014
Michael Suk	1994-1995
Andrew M. Thomas	1997-1999
Jeffrey A. Towson	1998-1999
Georgia A. Tuttle	2011-2019
Jordan M. VanLare	2011-2012
Robert M. Wah	2005-2013
Peter Y. Watson	2001-2003
Monica C. Wehby	2011-2013
Kevin W. Williams	2016-2020
Meredith C. Williams	2010-2011
Cecil B. Wilson	2002-2009
Percy Wootton	1991-1996

SPECIALTY AND SERVICE SOCIETY REPRESENTATIVES

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

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

MEMBERS OF THE HOUSE OF DELEGATES - JUNE 2022
The following is a list of delegates and alternate delegates to the House of Delegates as reported to the Executive Vice President

Medical Association of the State of Alabama

Delegate(s)
Steven P. Furr, Jackson AL
B Jerry Harrison, Haleyville AL
George C. Smith, Lineville AL
Tom Weida, Tuscaloosa AL

Alternate Delegate(s)
Julia Boothe, Reform AL
Alexis Mason, Tuscaloosa AL
John Meigs Jr, Brent AL
William Schneider, Huntsville AL

Regional Medical Student Alternate Delegate(s)
Lucian Bloodworth, Mountain Brk AL

Alaska State Medical Association

Delegate(s)
Alex Malter, Juneau AK

Alternate Delegate(s)
Rhene Merkouris, Anchorage AK

Arizona Medical Association

Delegate(s)
Daniel P. Aspery, Phoenix AZ
Veronica K. Dowling, Lakeside AZ
Timothy Fagan, Tucson AZ
M Zuhdi Jasser, Phoenix AZ
Marc Leib, Phoenix AZ

Alternate Delegate(s)
Jennifer Hartmark-Hill, Phoenix AZ
Jacquelyn Hoffman, Tucson AZ
Susan M. Whitely, Phoenix AZ

Arizona Medical Association

Regional Medical Student Delegate(s)
Will Collins, Tucson AZ

Regional Medical Student Alternate Delegate(s)
Amrutha Doniparthi, Yuma AZ

Arkansas Medical Society

Delegate(s)
Omar Atiq, Little Rock AR
Eugene Shelby, Little Rock AR
Alan Wilson, Monticello AR

Alternate Delegate(s)
Amy Cahill, White Hall AR
Stephen Magie, Conway AR

Regional Medical Student Alternate Delegate(s)
Olivia Tzeng, Conway AR

California Medical Association

Delegate(s)
Jerry P Abraham, Los Angeles CA
Barbara J. Arnold, Sacramento CA
Patricia L. Austin, Alamo CA
Dirk Stephen Baumann, Burlingame CA
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Delegate(s)
Carolyn M. Clancy, Silver Spring MD

Current as of: 5/5/2022

Academic Physicians Section

Delegate(s)
Alma B. Littles, Tallahassee FL

Alternate Delegate(s)
Suzanne M. Allen, Boise ID

Integrated Physician Practice Section

Delegate(s)
Steven Wang, Bakersfield CA

Alternate Delegate(s)
Russell C. Libby, Fairfax VA

International Medical Graduates Section

Delegate(s)
Natalia Solenkova, Aventura FL

Alternate Delegate(s)
Afifa Adiba, Wallingford CT

Medical Student Section

Delegate(s)
Anna Heffron, Madison WI

Alternate Delegate(s)
Tristan Mackey, Greenville SC

Minority Affairs Section

Delegate(s)
Luis Seija, New York NY

Alternate Delegate(s)
Michael G. Knight, Washington DC

Organized Medical Staff Section

Delegate(s)
Matthew Gold, Winchester MA

Alternate Delegate(s)
Nancy Fan, Wilmington DE

Private Practice Physician Section

Delegate(s)
Timothy G. Mc Avoy, Waukesha WI

Alternate Delegate(s)
Daniel Eunsuk Choi, New Hyde Park NY

Resident and Fellow Section

Delegate(s)
Raymond Lorenzoni, Bronx NY

Alternate Delegate(s)
Daniel Pfeifle, Rochester MN

Senior Physicians Section

Delegate(s)
Louise B. Andrew, Sidney BC

Alternate Delegate(s)
Thomas E. Sullivan, Beverly MA

Women Physicians Section

Delegate(s)
Nicole L. Plenty, Katy TX

Alternate Delegate(s)
Anna Laucis, Green Bay WI

Young Physicians Section

Delegate(s)
Kavita Arora, Chapel Hill NC

Alternate Delegate(s)
Alisha Reiss, Greenville OH

Current as of: 5/5/2022

AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES

2022 Annual Meeting
Notes on Orders of Business
Grand Ballroom, Hyatt Regency Chicago

FIRST SESSION, Friday, June 10, 5:30 – 7:30 pm

SECOND SESSION, Saturday, June 11, 12:30 – 1:00 pm

THIRD SESSION, Monday, June 13, 10:00 am – 6:00 pm

FOURTH SESSION, Tuesday, June 14, 8:30 am (or 10 minutes after Election Session) – 3:30 pm

> *Note: The Inauguration of Jack Resneck, MD, as the 177th President of the American Medical Association, will be held at 5:30 pm in the Crystal Ballroom of the Hyatt Regency Chicago.*

FIFTH SESSION, Wednesday, June 15, 8:00 am – completion of business

SUMMARY OF FISCAL NOTES (JUNE 2022 ANNUAL MEETING)

BOT Report(s)

01 Annual Report: Informational report
02 New Specialty Organizations Representation in the House of Delegates: Minimal
03 2021 Grants and Donations: Informational report
04 AMA 2023 Dues: Minimal
05 Update on Corporate Relationships: Informational report
06 Redefining AMA's Position on ACA and Healthcare Reform: Informational report
07 AMA Performance, Activities and Status in 2021: Informational report
08 Annual Update on Activities and Progress in Tobacco Control: March 2021 through February 2022: Informational report
09 Council on Legislation Sunset Review of 2012 House Policies: Minimal
10 American Medical Association Center for Health Equity Annual Report: Informational report
11 Procedure for Altering the Size or Composition of Section Governing Councils: Modest
12 Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent: Informational report
13 Use of Psychiatric Advance Directives: Minimal
14 Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954: Minimal
15 Addressing Public Health Disinformation: $100,000
16 Language Proficiency Data of Physicians in the AMA Masterfile: Minimal
17 Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession: Modest
18 Addressing Inflammatory and Untruthful Online Ratings: Minimal
19 Demographic Report of the House of Delegates and AMA Membership: Informational report
20 Delegate Apportionment and Pending Members: Modest
21 Opposition to Requirements for Gender-Based Treatments for Athletes: Minimal

CC&B Report(s)

01 Clarification to the Bylaws: Delegate Representation: Miminal

CEJA Opinion(s)

01 Amendment to E-1.1.6, Quality: Informational Report
02 Amendment to E-1.2.11, Ethical Innovation in Medical Practice: Informational Report
03 Amendment to E-11.1.2, Physician Stewardship of Health Care Resources: Informational Report
04 Amendment to E-11.2.1, Professionalism in Health Care Systems: Informational Report

CEJA Report(s)

01 Short-Term Medical Service Trips: Miminal
02 Amendment to Opinion 10.8, Collaborative Care: Miminal
03 Amendment to E-9.3.2, Physician Responsibilities to Colleagues with Illness, Disability or Impairment: Miminal
04 CEJA's Sunset Review of 2012 House Policies: Miminal
05 Pandemic Ethics and the Duty of Care (D-130.960): Informational Report
06 Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report: Informational Report

CME Report(s)

01 Council on Medical Education Sunset Review of 2012 House Policies: Miminal

SUMMARY OF FISCAL NOTES (JUNE 2022 ANNUAL MEETING)

CME Report(s)

02 An Update on Continuing Board Certification: Modest
03 Onsite and Subsidized Childcare for Medical Students, Residents and Fellows: Modest
04 Protection of Terms Describing Physician Education and Practice: Modest
05 Education, Training and Credentialing of Non-Physician Health Care Providers and Their Impact on Physician Education and Training: Miminal
06 Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows: Modest

CMS Report(s)

01 Council on Medical Service Sunset Review of 2012 House Policies: Minimal
02 Prospective Payment Model Best Practices for Independent Private Practice: Minimal
03 Preventing Coverage Losses After the Public Health Emergency Ends: Minimal
04 Parameters of Medicare Drug Price Negotiation: Minimal
05 Poverty-Level Wages and Health: Minimal

CSAPH Report(s)

01 Council on Science and Public Health Sunset Review of 2012 HOD Policies: Minimal
02 Transformation of Rural Community Public Health Systems: Modest
03 Correcting Policy H-120.958: Minimal

Joint Report(s)

CCB/CLRPD 01 Joint Council Sunset Review of 2012 House Policies: Minimal

Report of the Speakers

01 Recommendations for Policy Reconciliation: Informational Report

Resolution(s)

001 Increasing Public Umbilical Cord Blood-Donations in Transplant Centers: Modest
002 Opposition to Discriminatory Treatment of Haitian Asylum Seekers: Minimal
003 Gender Equity and Female Physician Work Patterns During the Pandemic: Minimal
004 Recognizing LGBTQ+ Individuals as Underrepresented in Medicine: Modest
005 Supporting the Study of Reparations as a Means to Reduce Racial Inequalities: Estimated cost to implement this resolution is $110,000. Estimate includes current and new staff (new complement positions or use of contract labor) costs.
006 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism: Minimal
007 Equal Access for Adoption in the LGBTQ Community: Minimal
008 Student-Centered Approaches for Reforming School Disciplinary Policies: Minimal
009 Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent: Minimal
010 Improving the Health and Safety of Sex Workers: Minimal
011 Evaluating Scientific Journal Articles for Racial and Ethic Bias: Minimal
012 Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions: Minimal
013 Recognition of National Anti-Lynching Legislation as a Public Health Initiative: Minimal
101 Fertility Preservation Benefits for Active-Duty Military Personnel: Modest
102 Bundling Physician Fees with Hospital Fees: Minimal

SUMMARY OF FISCAL NOTES (JUNE 2022 ANNUAL MEETING)

Resolution(s)

103 COBRA for College Students: Modest
104 Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for Health Care Financing: Modest
105 Health Insurance that Fairly Compensates Physicians: Modest
106 Hospice Recertification for Non-Cancer Diagnosis: Modest
107 Medicaid Tax Benefits: Modest
108 Payment for Regadenoson (Lexiscan): Modest
109 Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits: Modest
110 Private Payor Payment Integrity: Modest
111 Bundled Payments and Medically Necessary Care: Modest
112 Support for Easy Enrollment Federal Legislation: Modest
113 Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation: Modest
114 Oral Healthcare IS Healthcare: Modest
115 Support for Universal Internet Access: Modest
116 Reimbursement of School-Based Health Centers: Minimal
117 Expanding Medicaid Transportation to Include Healthy Grocery Destinations: Modest
118 Caps on Insulin Co-Payments for Patients with Insurance: Minimal
119 Medicare Coverage of Dental, Vision and Hearing Services: Minimal
120 Expanding Coverage for and Access to Pulmonary Rehabilitation: Modest
121 Increase Funding, Research and Education for Post-Intensive Care Syndrome: Modest
122 Medicaid Expansion: Modest
123 Advocating for All Payer Coverage of Cosmetic Treatment for Survivors of Domestic Abuse and Intimate Partner Violence: Modest
124 To Require Insurance Companies Make the "Coverage Year" and the "Deductible Year" Simultaneous for Their Policies: Modest
125 Education, Forewarning and Disclosure Regarding Consequences of Changing Medicare Plans: Minimal
201 The Impact of Midlevel Providers on Medical Education: Estimated cost of $50K to hire outside consultants to conduct research and analysis.
202 AMA Position on All Payer Database Creation: Modest
203 Ban the Gay/Trans (LGBTQ+) Panic Defense: Modest
204 Insurance Claims Data: Modest
205 Insurers and Vertical Integration: Modest
206 Medicare Advantage Plan Mandates: Modest
207 Physician Tax Fairness: Modest
208 Prohibit Ghost Guns: Minimal
209 Supporting Collection of Data on Medical Repatriation: Modest
210 Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits: Modest
211 Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program: Modest
212 Medication for Opioid Use Disorder in Physician Health Programs: Modest
213 Resentencing for Individuals Convicted of Marijuana-Based Offenses: Minimal
214 Eliminating Unfunded or Unproven Mandates and Regulations: Modest
215 Transforming Professional Licensure to the 21st Century: Modest
216 Advocating for the Elimination of Hepatitis C Treatment Restrictions: Modest

SUMMARY OF FISCAL NOTES (JUNE 2022 ANNUAL MEETING)

Resolution(s)

217 Preserving the Practice of Medicine: $462,000 to conduct research and analysis in house ($77,000), and hire outside consultants to conduct research, analysis, surveys and analysis of results ($385,000).
218 Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas: Modest
219 Due Process and Independent Contractors: Modest
220 Vital Nature of Board-Certified Physicians in Aerospace Medicine: Modest
301 Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic: Modest
302 Resident and Fellow Access to Fertility Preservation: Minimal
303 Fatigue Mitigation Respite for Faculty and Residents: Minimal
304 Organizational Accountability to Resident and Fellow Trainees: Modest
305 Reducing Overall Fees and Making Costs for Licensing Exam Fees, Application Fees, Etc., Equitable for IMGs: Minimal
306 Creating a More Accurate Accounting of Medical Education Financial Costs: Modest
307 Parental Leave and Planning Resources for Medical Students: Minimal
308 University Land Grant Status in Medical School Admissions: Modest
309 Decreasing Bias in Evaluations of Medical Student Performance: Modest
310 Support for Standardized Interpreter Training: Moderate
311 Discontinue State Licensure Requirement for COMLEX Level 2 PE: Minimal
312 Reduce Financial Burden to Medical Students of Medical Licensure Examinations: Minimal
313 Decreasing Medical Student Debt and Increasing Transparency in Cost of Medical School Attendance: Modest
314 Support for Institutional Policies for Personal Days for Undergraduate Medical Students: Minimal
315 Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program: Minimal
316 Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools: Minimal
317 Medical Student, Resident and Fellow Suicide Reporting: Moderate
401 Air Quality and the Protection of Citizen Health: Modest
402 Support for Impairment Research: Modest
403 Addressing Maternal Discrimination and Support for Flexible Family Leave: Minimal
404 Weapons in Correctional Healthcare Facilities: Modest
405 Universal Childcare and Preschool: Moderate
406 COVID-19 Preventive Measures for Correctional Facilities: AMA Policy Position: Modest
407 Study of Best Practices for Acute Care of Patients in the Custody of the Law: Modest
408 Supporting Increased Research on Implementation of Nonviolent De-escalation Training and Mental Illness Awareness in Law Enforcement: Minimal
409 Increasing HPV Vaccination Rates in Rural Communities: Modest
410 Increasing Education for School Staff to Recognize Prodromal Symptoms of Schizophrenia in Teens and Young Adults to Increase Early Intervention: Modest
411 Anonymous Prescribing Option for Expedited Partner Therapy: not yet determined
412 Advocating for the Amendment of Chronic Nuisance Ordinances: Modest
413 Expansion on Comprehensive Sexual Health Education: Minimal
414 Improvement of Care and Resource Allocation for Homeless Persons in the Global Pandemic: Modest
415 Creation of an Obesity Task Force: Moderate
416 School Resource Officer Violence De-Escalation Training and Certification: Modest
417 Tobacco Control: Minimal
418 Lung Cancer Screening Awareness: Moderate

SUMMARY OF FISCAL NOTES (JUNE 2022 ANNUAL MEETING)

Resolution(s)

419 Advocating for the Utilization of Police and Mental Health Care Co-Response Teams for 911 Mental Health Emergency Calls: Minimal
501 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use: Minimal
502 Ensuring Correct Drug Dispensing: Minimal
503 Pharmacy Benefit Managers and Drug Shortages: Modest
504 Scientific Studies Which Support Legislative Agendas: Minimal
505 CBD Oil Use and the Marketing of CBD Oil: Minimal
506 Drug Manufacturing Safety: Modest
507 Federal Initiative to Treat Cannabis Dependence: Modest
508 Supplemental Resources for Inflight Medical Kit: Modest
509 Regulation and Control of Self-Service Labs: Modest
510 Evidence-Based Deferral Periods for MSM Cornea and Tissue Donors: Minimal
511 Over the Counter (OTC) Hormonal Birth Control: Modest
512 Scheduling and Banning the Sale of Tianeptine in the United States: Modest
513 Education for Patients on Opiate Replacement Therapy: not yet determined
514 Oppose Petition to the DEA and FDA on Gabapentin: Modest
515 Reducing Polypharmacy as a Significant Contributor to Senior Morbidity: not yet determined
601 Development of Resources on End-of-Life Care: Modest
602 Report on the Preservation of Independent Medical Practice: Modest
603 September 11th as a National Holiday: Minimal
604 UN International Radionuclide Therapy Day Recognition: Minimal
605 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis: Pending
606 Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System: Modest
607 AMA Urges Health and Life Insurers to Divest of Investments of Fossil Fuels: Modest
608 Transparency of Resolution Fiscal Notes: Estimated cost of $5,810 annually based on the average volume of HOD business during in-person meetings over the three-year period 2017-2019.
609 Surveillance Management System for Organized Medicine Policies and Reports: Modest
610 Making AMA Meetings Accessible: not yet determined
701 Appeals and Denial - CPT Codes for Fair Compensation: Minimal
702 Health System Consolidation: Modest
703 Mandatory Reporting of All Antipsychotic Drug Use in Nursing Home Residents: Minimal
704 Employed Physician Contracts: Minimal
705 Fifteen Month Lab Standing Orders: Modest
706 Government Imposed Volume Requirements for Credentialing: Modest
707 Insurance Coverage for Scalp Cooling (Cold Cap) Therapy: Modest
708 Physician Burnout is an OSHA Issue: Modest
709 Physician Well-Being as an Indicator of Health System Quality: Minimal
710 Prior Authorization - CPT Codes for Fair Compensation: Minimal
711 Reducing Prior Authorization Burden: Modest
712 The Quadruple Aim - Promoting Improvement in the Physician Experience of Providing Care: Minimal
713 Enforcement of Administrative Simplification Requirements: Modest

SUMMARY OF FISCAL NOTES (JUNE 2022 ANNUAL MEETING)

Resolution(s)

714 Prior Authorization Reform for Specialty Medications: Modest
715 Prior Authorization - CPT Codes for Fair Compensation: Modest
716 Discharge Summary Reform: Moderate
717 Expanding the AMA's Study on the Economic Impact of COVID-19: Modest
718 Degradation of Medical Records: Miminal
719 System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access: Modest
720 Mitigating the Negative Impact of Step Therapy Policies and Nonmedical Switching of Prescription Drugs on Patient Safety: Minimal
721 Amend AMA Policy H-215.981 Corporate Practice of Medicine: Minimal
722 Eliminating Claims Data for Measuring Physician and Hospital Quality: Modest

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

LISTING OF RESOLUTIONS BY SPONSOR
JUNE 2022 ANNUAL MEETING

AEROSPACE MEDICAL ASSOCIATION

220 Vital Nature of Board-Certified Physicians in Aerospace Medicine

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

404 Weapons in Correctional Healthcare Facilities

AMERICAN ACADEMY OF NEUROLOGY

211 Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program

AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION

111 Bundled Payments and Medically Necessary Care

AMERICAN ASSOCIATION OF PHYSICIANS OF INDIAN ORIGIN

218 Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas

AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS

406 COVID-19 Preventive Measures for Correctional Facilities: AMA Policy Position
607 AMA Urges Health and Life Insurers to Divest of Investments of Fossil Fuels

AMERICAN COLLEGE OF CARDIOLOGY

215 Transforming Professional Licensure to the 21st Century

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

219 Due Process and Independent Contractors

AMERICAN THORACIC SOCIETY

120 Expanding Coverage for and Access to Pulmonary Rehabilitation
407 Study of Best Practices for Acute Care of Patients in the Custody of the Law

COLORADO

510 Evidence-Based Deferral Periods for MSM Cornea and Tissue Donors

GEORGIA

609 Surveillance Management System for Organized Medicine Policies and Reports

ILLINOIS

009 Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent
115 Support for Universal Internet Access
123 Advocating for All Payer Coverage of Cosmetic Treatment for Survivors of Domestic Abuse and Intimate Partner Violence
124 To Require Insurance Companies Make the "Coverage Year" and the "Deductible Year" Simultaneous for Their Policies
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505 CBD Oil Use and the Marketing of CBD Oil
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507 Federal Initiative to Treat Cannabis Dependence
508 Supplemental Resources for Inflight Medical Kit
509 Regulation and Control of Self-Service Labs
511 Over the Counter (OTC) Hormonal Birth Control
718 Degradation of Medical Records
720 Mitigating the Negative Impact of Step Therapy Policies and Nonmedical Switching of Prescription Drugs on Patient Safety

MARYLAND

112 Support for Easy Enrollment Federal Legislation
703 Mandatory Reporting of All Antipsychotic Drug Use in Nursing Home Residents

MEDICAL STUDENT SECTION

004 Recognizing LGBTQ+ Individuals as Underrepresented in Medicine
005 Supporting the Study of Reparations as a Means to Reduce Racial Inequalities
006 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism
007 Equal Access for Adoption in the LGBTQ Community
008 Student-Centered Approaches for Reforming School Disciplinary Policies
010 Improving the Health and Safety of Sex Workers
011 Evaluating Scientific Journal Articles for Racial and Ethic Bias
012 Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions
116 Reimbursement of School-Based Health Centers
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314 Support for Institutional Policies for Personal Days for Undergraduate Medical Students
315 Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program
405 Universal Childcare and Preschool
412 Advocating for the Amendment of Chronic Nuisance Ordinances
413 Expansion on Comprehensive Sexual Health Education

MICHIGAN

122 Medicaid Expansion
212 Medication for Opioid Use Disorder in Physician Health Programs
213 Resentencing for Individuals Convicted of Marijuana-Based Offenses
411 Anonymous Prescribing Option for Expedited Partner Therapy
606 Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System

MISSISSIPPI

512 Scheduling and Banning the Sale of Tianeptine in the United States

NEW YORK

002 Opposition to Discriminatory Treatment of Haitian Asylum Seekers
102 Bundling Physician Fees with Hospital Fees
103 COBRA for College Students
104 Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for Health Care Financing
105 Health Insurance that Fairly Compensates Physicians
106 Hospice Recertification for Non-Cancer Diagnosis
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710 Prior Authorization - CPT Codes for Fair Compensation
711 Reducing Prior Authorization Burden
712 The Quadruple Aim - Promoting Improvement in the Physician Experience of Providing Care

OBESITY MEDICINE ASSOCIATION

415 Creation of an Obesity Task Force

OHIO

214 Eliminating Unfunded or Unproven Mandates and Regulations
719 System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access

OKLAHOMA

416 School Resource Officer Violence De-Escalation Training and Certification
417 Tobacco Control
418 Lung Cancer Screening Awareness
513 Education for Patients on Opiate Replacement Therapy
514 Oppose Petition to the DEA and FDA on Gabapentin
722 Eliminating Claims Data for Measuring Physician and Hospital Quality

ORGANIZED MEDICAL STAFF SECTION

714 Prior Authorization Reform for Specialty Medications
716 Discharge Summary Reform

PRIVATE PRACTICE PHYSICIAN SECTION

701 Appeals and Denial - CPT Codes for Fair Compensation
702 Health System Consolidation
713 Enforcement of Administrative Simplification Requirements
715 Prior Authorization - CPT Codes for Fair Compensation

RESIDENT AND FELLOW SECTION

013 Recognition of National Anti-Lynching Legislation as a Public Health Initiative
201 The Impact of Midlevel Providers on Medical Education
217 Preserving the Practice of Medicine
302 Resident and Fellow Access to Fertility Preservation
304 Organizational Accountability to Resident and Fellow Trainees
305 Reducing Overall Fees and Making Costs for Licensing Exam Fees, Application Fees, Etc., Equitable for IMGs
414 Improvement of Care and Resource Allocation for Homeless Persons in the Global Pandemic
605 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis
608 Transparency of Resolution Fiscal Notes
717 Expanding the AMA's Study on the Economic Impact of COVID-19
721 Amend AMA Policy H-215.981 Corporate Practice of Medicine

SENIOR PHYSICIANS SECTION

113 Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation
114 Oral Healthcare IS Healthcare
125 Education, Forewarning and Disclosure Regarding Consequences of Changing Medicare Plans
515 Reducing Polypharmacy as a Significant Contributor to Senior Morbidity
610 Making AMA Meetings Accessible

SOCIETY OF CRITICAL CARE MEDICINE

121 Increase Funding, Research and Education for Post-Intensive Care Syndrome

WOMENT PHYSICIANS SECTION

003 Gender Equity and Female Physician Work Patterns During the Pandemic
303 Fatigue Mitigation Respite for Faculty and Residents
403 Addressing Maternal Discrimination and Support for Flexible Family Leave

YOUNG PHYSICIANS SECTION

001 Increasing Public Umbilical Cord Blood-Donations in Transplant Centers
101 Fertility Preservation Benefits for Active-Duty Military Personnel
501 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

02 New Specialty Organizations Representation in the House of Delegates
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14 Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954
21 Opposition to Requirements for Gender-Based Treatments for Athletes

CC&B Report(s)

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CEJA Report(s)

01 Short-Term Medical Service Trips
02 Amendment to Opinion 10.8, Collaborative Care
03 Amendment to E-9.3.2, Physician Responsibilities to Colleagues with Illness, Disability or Impairment
04 CEJA's Sunset Review of 2012 House Policies

Resolution(s)

001 Increasing Public Umbilical Cord Blood-Donations in Transplant Centers
002 Opposition to Discriminatory Treatment of Haitian Asylum Seekers
003 Gender Equity and Female Physician Work Patterns During the Pandemic
004 Recognizing LGBTQ+ Individuals as Underrepresented in Medicine
005 Supporting the Study of Reparations as a Means to Reduce Racial Inequalities
006 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism
007 Equal Access for Adoption in the LGBTQ Community
008 Student-Centered Approaches for Reforming School Disciplinary Policies
009 Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent
010 Improving the Health and Safety of Sex Workers
011 Evaluating Scientific Journal Articles for Racial and Ethic Bias
012 Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions
013 Recognition of National Anti-Lynching Legislation as a Public Health Initiative

REPORT OF THE BOARD OF TRUSTEES

B of T Report 2-A-22

Subject: New Specialty Organizations Representation in the House of Delegates

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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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, Americas 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, Americas 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, Americas 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. (Directive to Take Action)

Fiscal Note: Less than $500

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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%)
Americas Hernia Society	217 of 1,006 (22%)
Outpatient Endovascular and Interventional Society	101 of 250 (40%)

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-A-22

Subject: "Use of Psychiatric Advance Directives" (Resolution 1-I-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution & Bylaws

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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

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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 executive 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 themself 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; (New HOD Policy) 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. (New HOD Policy)

Fiscal note: Less than $500

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-A-22

Subject: Amendment to Truth and Transparency in Pregnancy Counseling Centers, Policy H-420.954 (Resolution 8-N-21)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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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 provide~~s~~, 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.

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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 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, medically accurate, health information to support patients' informed, voluntary decisions. (Modify Current HOD Policy)

Fiscal note: less than $500.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 21-A-22

Subject: Opposition to Requirements for Gender-Based Treatments for Athletes (Resolution 19-A-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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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].

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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].

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[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.

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 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; (New HOD Policy)

2. That our AMA oppose use of specific hormonal guidelines to determine gender classification for athletic competitions. (New HOD Policy)

Fiscal note: Less than $500.

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-A-22

Subject: Clarification to the Bylaws: Delegate Representation

Presented by: Pino Colone, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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At the 2019 Annual Meeting, the House referred CCB Report 1, "Clarifications to the Bylaws – Delegate Representation, Registration and Credentialing," to the Council for report back. At the 2019 meeting, the House adopted two Council reports that included elements of referred CCB Report 1-A-19. This third report focuses on the general issue of representation in our AMA House of Delegates (HOD), with clarifying language regarding the medical student regional delegates and the delegates from the Resident and Fellow Section.

DELEGATE REPRESENTATION

Our AMA HOD, per Article IV of the AMA Constitution, is the legislative and policymaking body of the Association. Article III establishes that the AMA is comprised of individual members who are represented through constituent associations, national medical specialty societies and other entities, as specified in the Bylaws. Since delegates and alternate delegates can only achieve HOD representation via one of the aforementioned entities, which includes the sections, the Council opines that an underlying premise of the various AMA bylaws is that a delegate can only represent an organization of which he/she is a member. Bylaw 2.0.1.2 speaks to the multi-dimensional role of delegates, including representation of the perspectives of the delegate's sponsoring organization, and Bylaw 2.10.3, "Lack of Credentials" alludes to the need for "proper identification as the delegate or alternate delegate selected by the respective organization."

There was limited discussion of the Council's recommendation in CCB Report 1-A-19 mandating delegate membership in the entity one is representing. Thus, the Council reintroduces amendments to address the representation requirement of delegates to our AMA House of Delegates.

Other more controversial issues touching on regional medical student representation and RFS sectional delegates from CCB 1-A-19 are discussed below.

REGIONAL MEDICAL STUDENT REPRESENTATION

Similar to the other AMA sections, the Medical Student Section (MSS) elects a delegate and an alternate delegate. In addition, there are medical student regional delegates and alternate delegates. There are seven medical student regions defined for the purposes of electing regional delegates to the AMA House of Delegates. Per Bylaw 2.3.2, each medical student region, as defined by the Medical Student Section, is entitled to "one delegate and one alternate delegate for each 2,000 active medical student members of the AMA in an educational program located within the jurisdiction of the medical student region." The regions are as follows:

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Region 1: Washington, Oregon, California, Nevada, Utah, Colorado, Arizona, New Mexico, Montana, North Dakota, South Dakota, Idaho, Wyoming, Alaska, Hawaii.
Region 2: Minnesota, Wisconsin, Nebraska, Iowa, Missouri, Illinois.
Region 3: Kansas, Texas, Oklahoma, Arkansas, Louisiana, Mississippi.
Region 4: Florida, Georgia, Alabama, South Carolina, North Carolina, Tennessee, Puerto Rico.
Region 5: Michigan, Indiana, Ohio, Kentucky, West Virginia.
Region 6: Virginia, Maryland, District of Columbia, Delaware, New Jersey, Pennsylvania.
Region 7: Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New York.

Per Bylaw 2.3.3, "Each elected medical student section delegate must receive written endorsement from the constituent association representing the jurisdiction within which the medical student's educational program is located, in accordance with procedures adopted by the MSS and approved by the Board of Trustees." The medical student regional delegate and alternate delegate positions are typically funded by the endorsing constituent association, although there is no requirement to do so. Each regional medical student delegate is seated with his/her endorsing constituent association, again per AMA bylaws, with any student who subsequently substitutes for that regional medical student delegate seated with that same constituent association.

At the A-19 Reference Committee on Amendments to Constitution and Bylaws, there was divergent testimony as to what entity a medical student regional delegate represents in the House of Delegates. A candidate standing for election to a medical student regional delegate or alternate delegate position must be endorsed by a constituent association; at the MSS meeting, medical students from the same region vote to elect one or more candidates from the region. Yet a medical student regional delegate has <u>some</u> obligation to the constituent association that endorsed their candidacy and that often funds their participation. The Council acknowledges that the medical student regional delegates to the House of Delegates have competing loyalties to their endorsing constituent association, the MSS, their medical student region and their educational program, and that the positions of each may differ on important items of business. Furthermore, AMA Bylaw 2.0.1.2. acknowledges this multi-dimensional role of <u>all</u> AMA delegates. The Council, however, continues to believe that membership in the endorsing constituent association is essential for any medical student regional delegate and thus should be articulated in our AMA Bylaws.

In proposing amendments to Bylaw 2.3, the Council has included language that parallels that in the Medical Student Section's Internal Operating Procedures approved by the Board of Trustees to address the qualifications of the medical student regional delegate and the regional delegate substitution process. The Council believes that the House of Delegates, endorsing constituent associations, and AMA delegations should be familiar with the Board-approved process when there are vacancies. Again, the Council stands by its language regarding membership in the endorsing constituent association for the medical student regional delegates and alternate delegates.

The Council also has expanded existing bylaw language in 2.10.8 to provide clarity regarding the seating of substitute medical student regional delegates in the House of Delegates. The new language is consistent with current practice as approved by the Board and addressed in the Internal Operating Procedures.

Lastly, the Council also heard some concerns in 2019 from medical students who train full time in a state different than the state where their educational program is located. The Council has learned that the Medical Student Section is seeking to revise the language in its Internal Operating Procedures that speaks to this issue specifically as well as other issues associated with multiple medical student campuses, so in this report the Council also is proposing amendments to Bylaws

2.3.3 and 2.10.8 to eliminate language referring to the jurisdiction of the medical student's educational program.

RFS REPRESENTATION

Similar to other AMA Sections, the Resident and Fellow Section (RFS) has a single delegate and alternate delegate. Additional RFS delegates and alternate delegates to the House of Delegates are elected at the RFS Assembly meeting based on the apportionment of one delegate for every 2,000 active resident and fellow members of the AMA. These sectional RFS delegates must be endorsed by a constituent association, a national medical specialty society, a professional interest association, or a federal service. These positions are typically funded by the endorsing association, society, or federal service and each RFS delegate is seated with the endorsing entity per AMA bylaws, with any resident who substitutes for an RFS delegate being seated with that same entity.

AMA Bylaw 2.0.1.2.1 states "In considering business, delegates should take into consideration the perspectives of their patients, their sponsoring organizations, and their physician constituents." Most delegations caucus prior to and during the House meeting and develop a delegation position on pending items of business. The Council acknowledges that the sectional RFS delegates, like the medical student regional delegates, have competing loyalties as they represent not only their endorsing/sponsoring/funding entity but the RFS in the House of Delegates, and that the positions of the sponsoring entity and the AMA section may differ on important items of business. As with the medical student regional delegates, the Council believes that membership in the endorsing entity is essential for the sectional RFS delegates and alternate delegates and thus should be articulated in our AMA Bylaws.

The Council notes that RFS delegate substitutions are more flexible as these individuals are elected at-large and not regionally as are the regional medical student delegates or even by specialty. The RFS procedures adopted by the RFS Assembly and the Board of Trustees state that "Sectional Delegate vacancies shall be filled by a temporary appointment from the available Sectional Alternate Delegates at the discretion of the RFS Delegate and Alternate Delegate. Sectional Alternate Delegate vacancies shall be filled by a temporary appointment of RFS members present at the current House of Delegates meeting at the discretion of the RFS Delegate and Alternate Delegate… Consideration in temporary appointments shall be given to members who maintain or increase diversity of RFS representation in the House of Delegates with regards to sponsoring state and specialty societies."

The Council has proposed changes to several bylaws to clarify that AMA membership and membership in the endorsing entity is required of each RFS sectional delegate and alternate delegate. RFS delegates may be endorsed by entities represented in the AMA House of Delegates other than constituent associations or national medical specialty societies, namely professional interest medical associations or federal services, a practice allowed under procedures adopted by the RFS Assembly and approved by the Board of Trustees.

The Council has also expanded the language in Bylaw 2.10.9 to address the seating of substitute RFS delegates in the House of Delegates.

RECOMMENDATIONS

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

2.0.1 Composition and Representation. The House of Delegates is composed of delegates selected by recognized constituent associations and specialty societies, and other delegates as provided in this bylaw.

2.0.1.1 Qualification of Members of the House of Delegates. Members of the House of Delegates must be active members of the AMA and of the entity they represent.

2.8 Alternate Delegates. Each organization represented in the House of Delegates may select an alternate delegate for each of its delegates entitled to be seated in the House of Delegates.

2.8.1 Qualifications. Alternate delegates must be active members of the AMA and of the entity they represent.

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2.3 Medical Student Regional Delegates. In addition to the delegate and alternate delegate representing the Medical Student Section, ~~regional~~ medical student regional delegates and regional alternate delegates shall be apportioned and elected as provided in this bylaw.

2.3.1 Qualifications. Medical ~~S~~student ~~R~~regional delegates and alternate delegates must be active medical student members of the AMA. In addition, medical student regional delegates and alternate delegates must be members of their endorsing constituent association. The region in which the endorsing society is located determines the student's region, and a medical student may serve as a regional delegate, alternate delegate or any form of substitute (pursuant to Bylaws 2.8.5 or 2.10.4) only for that region.

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2.3.3 Medical ~~S~~student ~~R~~regional delegates and alternates shall be elected by the Medical Student Section in accordance with procedures adopted by the Section. Each elected delegate and alternate delegate must receive written endorsement from ~~the~~ their constituent association ~~representing the jurisdiction within which the medical student's educational program is located~~, in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees. Delegates and alternate delegates shall be elected at the Business Meeting of the Medical Student Section prior to the Interim Meeting of the House of Delegates. Delegates and alternate delegates shall be seated at the next Annual Meeting of the House of Delegates.

2.4 Delegates from the Resident and Fellow Section. In addition to the delegate and alternate delegate representing the Resident and Fellow Section, resident and fellow physician delegates and alternate delegates shall be apportioned and elected in a manner as provided in this bylaw.

2.4.1 Qualifications. Delegates and alternate delegates from the Resident and Fellow Section must be active members of the Resident and Fellow Section of the AMA. In addition, resident and fellow physician delegates and alternate delegates must be members of their endorsing society or organization currently seated in the HOD.

2.4.2 Apportionment. The apportionment of delegates from the Resident and Fellow Section is one delegate for each 2,000 active resident and fellow physician members of the AMA, as recorded by the AMA on December 31 of each year.

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2.4.3 Election. Delegates and alternate delegates shall be elected by the Resident and Fellow Section in accordance with procedures adopted by the Section. Each delegate and alternate delegate must receive written endorsement from ~~his or her~~ a society or organization currently seated in the House of Delegates and ~~a constituent association or national medical specialty society,~~ in accordance with procedures adopted by the Resident and Fellow Section and approved by the Board of Trustees.

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2.10.8 Medical Student Seating. Each ~~M~~medical ~~S~~student ~~R~~regional delegate shall be seated with the student's endorsing constituent association ~~representing the jurisdiction within which such delegate's educational program is located~~. Alternate or substitute delegates shall be assigned to the original regional delegate's seat location during the time they are seated for the original delegate.

2.10.9 Resident and Fellow Seating. Each delegate from the Resident and Fellow Section shall be seated with the physician's endorsing society or organization ~~constituent association or specialty society~~. In the case where a delegate has been endorsed by multiple entities ~~both a constituent association and specialty society~~, the delegate must choose, prior to the election, with which delegation the delegate wishes to be seated. Alternate or substitute delegates shall be assigned to the original delegate's seat location during the time they are seated for the original delegate.

(Modify Bylaws)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-A-22

Subject: Short-Term Medical Service Trips

Presented by: Alexander M. Rosenau, DO, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings abroad for a period of days or weeks, have been promoted, in part, as a strategy for addressing global health inequities. Without question, such trips have benefitted thousands of individual patients. At the same time, short-term medical service trips have a problematic history and run the risk of causing harm to the patients and communities they intend to serve [1]. To minimize harm and maximize benefit volunteers, sponsors, and hosts must jointly prioritize activities to meet mutually agreed-on goals; navigate day-to-day collaboration across differences of culture, language, and history; and fairly allocate host and team resources in the local setting.

Ethics guidance alone can neither redress historical wrongs nor solve the underlying structural issues that drive medical need in resource-limited settings of course. But by making explicit the conditions under which short-term medical service trips are ethically sound and by articulating the fundamental ethical responsibilities of those who participate in or sponsor such trips, ethics guidance can promote immediate benefit to individuals *and* sustainable benefit for their communities. This report by the Council on Ethical and Judicial Affairs (CEJA) explores the challenges of short-term medical service trips and offers guidance for physicians, physicians in training, and sponsors to help them address ethical challenges of providing clinical care in resource-limited settings abroad.

THE APPEAL OF SHORT-TERM MEDICAL SERVICE TRIPS

Just how many clinicians volunteer to provide medical care in resource-limited settings abroad is difficult to estimate, but the number is large. By one estimate, in the U.S. some 21% of the nearly 3 billion dollars' worth of volunteer hours spent in international efforts in 2007 were medically related [2]. For trainees, in January 2015 the Consortium of Universities for Global Health identified more than 180 websites relating to global health opportunities [3]. The Association of American Medical Colleges found that among students who graduated in 2017–2018 between 25% and 31% reported having had some "global health experience" during medical school [4].

A variety of reasons motivate physicians and trainees to volunteer for service trips. For many, compelling motivations include the opportunities such trips offer to help address health inequities, to improve their diagnostic and technical skills as clinicians, or to explore global health as a topic of study [2]. Service trips can also serve less lofty goals of building one's resume and improving

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

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one's professional prospects, gaining the esteem of peers and family, or simply enjoying international travel [2].

A NOTE ON TERMINOLOGY

The literature is replete with different terms for the activity of traveling abroad to provide medical care on a volunteer basis, including "short-term medical volunteerism" [5], "short-term medical missions" [6], "short-term medical service trips" [7,8], "short-term experience in global health" [9,10], "global health field experience" [11], "global health experience," and "international health experience" [2]. Each has merit as a term of art.

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

MEDICAL SERVICE IN RESOURCE-LIMITED SETTINGS

Traditionally, short-term medical service trips focused on providing clinical care as a charitable activity, not infrequently under the auspices of faith-based institutions, whose primary goal was to address unmet medical needs [10]. Increasingly, such trips focus on the broader goal of improving the health and well-being of host communities [9]. Many now also offer training opportunities for medical students and residents [9,10,11]. Ideally, short-term medical service trips are part of larger, long-term efforts to build capacity in health care systems being visited, and ultimately to reduce global health disparities [9,10].

The medical needs of host communities differ from those of volunteers' home countries—volunteers may encounter patients with medical conditions volunteers have not seen before, or who present at more advanced stages of disease, or are complicated by "conditions, such as severe malnutrition, for which medical volunteers may have limited experience" [7]. At the same time, available treatment options may include medications or tools with which volunteers are not familiar.

By definition, short-term medical service trips take place in contexts of scarce resources. The communities they serve are "victims of social, economic, or environmental factors" who have limited access to health care [7], and often lack access to food, and economic and political power as well and "may feel unable to say no to charity in any form offered" [10]. Moreover, short-term medical service trips take place under the long shadow of colonialism, including medicine's role [12], and have been critiqued as perpetuating the colonial legacy of racism, exploitation, and dependency [1,10,13].

ETHICAL RESPONSIBILITIES IN SHORT-TERM MEDICAL SERVICE TRIPS

These realities define fundamental ethical responsibilities not only for those who volunteer, but equally for the individuals and organizations that sponsor short-term medical service trips. Emerging guidelines identify duties to maximize and enhance good clinical outcomes, to promote justice and sustainability, to minimize burdens on host communities, and to respect persons and local cultures [2,9,10,11].

Promoting Justice & Sustainability

If short-term medical service trips are to achieve their primary goal of improving the health of local host communities, they must commit not simply to addressing immediate, concrete needs, but to helping the community build its own capacity to provide health care. To that end, the near and longer-term goals of trips should be set in collaboration with the host community, not determined in advance solely by the interests or intent of trip sponsors and participants [7,9]. Trips should seek to balance community priorities with the training interests and abilities of participants [10], but in the first instance benefits should be those desired by the host community [9]. Likewise, interventions must be acceptable to the community [9].

Volunteers and sponsors involved with short-term medical service trips have a responsibility to ask how they can best use a trip's limited time and material resources to promote the long-term goal of developing local capacity. Will the trip train local health care providers? Build local infrastructure? Empower the community [7]? Ideally, a short-term medical service trip will be part of a collaboratively planned longer-term and evolving engagement with the host community [7,10].

Minimizing Potential for Harms & Burdens in Host Communities

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

Beyond lodging, food, and other direct costs of short-term medical service trips, which are usually reimbursed to host communities [9], such trips can place indirect, less material burdens on local communities. Physicians, trainees, and others who organize or participate in short-term medical service trips should be alert to possible unintended consequences that can undermine the value of a trip to both hosts and participants. Trips should not detract from or place significant burdens on local clinicians and resources, particularly in ways that negatively affect patients, jeopardize sustainability, or disrupt relationships between trainees and their home institutions [9,11]. For example, donations of medical supplies can address immediate need, but at the same time create burdens for the local health care system and jeopardize development by the local community of effective solutions to long-term supply problems [7].

Negotiating beforehand how visiting health care professionals will be expected to interact with the host community and the boundaries of the team's mission, skill, and training can surface possible impacts and allow them to be addressed before the team is in the field. Likewise, selecting team members whose skills and experience map to the needs and expectations of the host community can help minimize disruptive effects on local practice [11]. Advance preparation should include developing a plan to monitor and address ongoing costs and benefits to patients and host communities and institutions, including local trainees (when the trip includes providing training for the host community), once the team is in the field [11].

Respecting Persons & Cultures

Physicians and trainees who participate in short-term medical service trips face a host of challenges. Some of them are practical—resource limitations, unfamiliar medical needs, living conditions outside their experience, among many others. Some challenges are more philosophical, especially the challenge of navigating language(s) and norms they may never have encountered before, or not encountered with the same immediacy [1,2,9]. Striking a balance between Western medicine's understanding of the professional commitment to respect for persons and the

expectations of host communities rooted in other histories, traditions, and social structures calls for a level of discernment, sensitivity, and humility that may more often be seen as the skill set of an ethnographer than a clinician.

Individuals who travel abroad to provide medical care in resource-limited settings should be aware that the interactions they will have in the field will inevitably be cross-cultural. They should seek to become broadly knowledgeable about the communities in which they will work, such as the primary language(s) in which encounters will occur; predominant local "explanatory models" of health and illness; local expectations for how health care professionals behave toward patients and toward one another; and salient economic, political, and social dynamics. Volunteers should take advantage of resources that can help them begin to cultivate the "cultural sensitivity" they will need to provide safe, respectful, patient-centered care in the context of the specific host community [7,10,11].

Individuals do not bear this responsibility alone, of course. Organizations and institutions that sponsor short-term medical service trips have a responsibility to make appropriate orientation and training available to volunteers before they depart [11], in addition to working with host communities to put in place appropriate services, such as interpreters or local mentors, to support volunteers in the field.

The ethical obligation to respect the individual patients they serve and their host communities' cultural and social traditions does *not* obligate physicians and trainees "to violate fundamental personal values, standards of medical care or ethical practice, or the law" [9]. Volunteers will be challenged, rather, to negotiate compromises that preserve in some reasonable measure the values of both parties whenever possible [14]. Volunteers should be allowed to decline to participate in activities that violate deeply held personal beliefs, but they should reflect long and carefully before reaching such a decision [15].

GETTING INTO THE FIELD

To fulfill these fundamental ethical responsibilities, moreover, requires meeting other obligations with respect to organizing and carrying out short-term medical service trips. Specifically, sponsoring organizations and institutions have an obligation to ensure thoughtful, diligent preparation to promote a trip's overall goals, including appropriately preparing volunteers for the field experience. Physicians and trainees, for their part, have an obligation to choose thoughtfully those programs with which they affiliate themselves [1,2, 9,11].

Prepare Diligently

Guidelines from the American College of Physicians recognize that "predeparture preparation is itself an ethical obligation" [9, cf. 2]. Defining the goal(s) of a short-term medical service trip in collaboration with the host community helps to clarify what material resources will be needed in the field, and thus anticipate and minimize logistic burdens the trip may pose. Collaborative planning can similarly identify what clinical skills volunteers should be expected to bring to the effort, for example, and what activities they should be assigned, or whether local mentors are needed or desirable and how such relationships will be coordinated [11].

Importantly, thoughtful preparation includes determining what nonclinical skills and experience volunteers should have to contribute to the overall success of the service opportunity. For example, a primary goal of supporting capacity building in the local community calls for participants who

have "training and/or familiarity with principles of international development, social determinants of health, and public health systems" [10].

Adequately preparing physicians and trainees for short-term medical service trips encompasses planning with respect to issues of personal safety, vaccinations, unique personal health needs, travel, malpractice insurance, and local credentialing requirements [7]. Equally important, to contribute effectively and minimize "culture shock" and distress, volunteers need a basic understanding of the context in which they will be working [1,2,7]. Without expecting them to become experts in local culture, volunteers should have access to resources that will orient them to the language(s), traditions, norms, and expectations of the host community, not simply to the resource and clinical challenges they are likely to face. Volunteers should have sufficient knowledge to conduct themselves appropriately in the field setting, whether that is in how they dress, how they address or interact with different members of the community, or how they carry out their clinical responsibilities [7]. And they need to know whom they can turn to for guidance in the moment.

Preparation should also include explicit attention to the possibility that volunteers will encounter ethical dilemmas. Working in unfamiliar cultural settings and health care systems poses the real possibility for physicians and trainees that they will encounter situations in which they "are unable to act in ways that are consistent with ethics and their professional values" or "feel complicit in a moral wrong" [9]. Having strategies in place to address dilemmas when they arise and to debrief after the fact can help mitigate the impact of such experiences. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect withdrawing will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

Choose Thoughtfully

Individual physicians and trainees who volunteer for short-term medical service trips are not in a position to directly influence how such programs are organized or carried out. They can, however, by preference choose to participate in activities carried out by organizations that fulfill the ethical responsibilities discussed above [9,10,11]. Volunteers can select organizations and programs that demonstrate commitment to long-term, community-led efforts to build and sustain local health care resources over programs that provide episodic, stop-gap medical interventions, which can promote dependence on the cycle of foreign charitable assistance rather than development of local infrastructure [10].

Measure & Share Meaningful Outcomes

Organizations that sponsor short-term medical service trips have a responsibility to monitor and evaluate the effectiveness of their programs, [7,9,10]. The measures used to evaluate program outcomes should be appropriate to the program's goals as defined proactively in collaboration with the host community [9]; for example, some have suggested quality-adjusted life years (QALYs) [16]. Prospective participants should affiliate themselves with programs that demonstrate effectiveness in providing outcomes meaningful to the population they serve, rather than simple measures of process such as number of procedures performed [7]. Developing meaningful outcome measures will require thoughtful reflection on the knowledge and skills needed to address the specific situation of the community or communities being served and on what preparations are essential to maximize health benefits and avoid undue harm.

RECOMMENDATION

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

Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings for a period of days or weeks, have been promoted as a strategy to provide needed care to individual patients and, increasingly, as a means to address global health inequities. To the extent that such service trips also provide training and educational opportunities, they may offer benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills.

By definition, short-term medical service trips take place in contexts of scarce resources and in the shadow of colonial histories. These realities define fundamental ethical responsibilities for volunteers, sponsors, and hosts to jointly prioritize activities to meet mutually agreed-on goals; navigate day-to-day collaboration across differences of culture, language, and history; and fairly allocate host and team resources in the local setting. Participants and sponsors must focus not only on enabling good health outcomes for individual patients, but on promoting justice and sustainability, minimizing burdens on host communities, and respecting persons and local cultures. Responsibly carrying out short-term medical service trips requires diligent preparation on the part of participants and sponsors in collaboration with host communities.

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

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

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

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

careful consideration of the effect that will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

Sponsors of short-term medical service trips should:

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

(e) Proactively define appropriate roles and permissible range of practice for members of the volunteer team, including the training, experience, and oversight of team members required to provide acceptable safe, high-quality care in the host setting. Team members should practice only within the limits of their training and skills in keeping with the professional standards of the sponsor's country.

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

(New HOD/CEJA Policy)

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-A-22

Subject: Amendment to Opinion 10.8, Collaborative Care

Presented by: Alexander M. Rosenau, DO, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Recent years have seen the rise of nonphysician practitioners (e.g., nurse practitioners, physician assistants, midwives) as a growing share of health care providers in the United States. Moreover, nonphysician practitioners have gained increasing autonomy, authorized by state governments (e.g., legislatures and licensing boards) in response to the lobbying from professional associations, to ameliorate provider shortages, and in response to rising health care costs. Expanded autonomy has increased the interactions of independent nonphysician practitioners and physicians in care of patients. Increasingly nonphysician practitioners are seeking advanced training that results in a doctorate degree, such as "Doctor of Nursing." Such terminology sometimes results in misconception or confusion for both patients and physicians about the practitioner's skillset, training, and experience.

The following is an analysis of the ethical concerns centering on issues of transparency and misconception. In recognition of the growing relevance of the issue, the Council brings this analysis on its own initiative, offering an amendment to the AMA *Code of Medical Ethics* Opinion 10.8 Collaborative Care.

DESCRIPTION OF NONPHYSICIAN PRACTITIONERS

The term "nonphysician practitioners" denotes a broad range of professionals including nurse practitioners, physician assistants, midwives, doulas, pharmacists, and physical therapists. There are "multiple pathways" for one to become a nonphysician practitioner, the most common is a nurse earning a "master's degree or doctoral degree in nursing" after initial completion of a bachelor's degree [1]. However, the skillsets and experience of nonphysician practitioners are not the same as those of physicians. Hence, when a nonphysician practitioner identifies themselves as "Doctor" consistent with the degree they received, it may create confusion and be misleading to patients and other practitioners.

PATIENT CONFUSION AND MISCONCEPTION

Patient confusion and misconception about provider credentials is a significant concern. Data suggests that many patients are not sure who is and who is not a physician. For example, 47% of respondents in one survey indicated they believed optometrists were physicians (10% were unsure), while some 15% believed ophthalmologists are *not* (with 12% being unsure) [2]. Nineteen percent

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of respondents to the same survey believed nurse practitioners (NPs) to be physicians, although 74% identified them as nonphysicians.

Meanwhile, the range of professional titles of various NPs is wide and the issue is compounded by the fact that many NPs hold doctorate degrees [3]. While the PhD in nursing degree is the oldest and most traditional doctorate in the nursing profession, having its roots in the 1960s and 70s [4], Al-Agba and Bernard note how in "recent years, an explosion of doctorates in various medical professions has made the label of 'doctor' far less clear", a common example being that of the of the "Doctor of Nursing Practice" (DNP) [3]. The DNP, a professional practice doctorate (distinct from the research-oriented PhD), was first granted in the U.S. in 2001. As of 2020, there are now 348 DNP programs in the U.S. [3]. Critics argue that the rise of DNP programs is not about providing better patient care, but is rather a "political maneuver, designed to appropriate the title of 'doctor' and create a false sense of equivalence between nurse practitioners and physicians in the minds of the public" [3].

The problem of identification has been recognized by some states where NPs with a doctorate are only allowed to be "addressed as 'doctor' if the DNP clarifies that he or she is actually an NP" and some jurisdictions require NPs without a doctorate to have special identification that "unambiguously identifies them" [5]. From an ethical standpoint, NPs have a duty as do all health care practitioners, including physicians to be forthright with patients about their skill sets, education, or training, and to not allow any situation where a misconception is possible. Ambiguous representation of credentials is unethical, because it interferes with the patient's autonomy, as the patient is not able to execute valid informed consent if they misconstrue the provider. For example, a patient may only want a certain procedure done by a physician and then assent to an NP performing the procedure, under the mistaken belief that the NP is a physician. However, such an assent to the medical procedure is neither a valid *consent* nor an adequately informed *assent*, as the patient's decision is founded on a flawed basis of key information, i.e., the nature and extent of the practitioner's skill set, education, and experience.

GUIDANCE IN AMA POLICY AND CODE OF MEDICAL ETHICS

AMA House Policy and the AMA *Code of Medical Ethics* respond to and recognize issues of transparency of credentials and professional identification. However, the *Code* could be modestly amended to offer specific guidance regarding transparency in the context of team-based care involving nonphysician practitioners.

House Policy

H-405.992 – "Doctor as Title," states:

> The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title ""Doctor," which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ.

D-405.991 – "Clarification of the Title "Doctor" in the Hospital Environment," states:

> Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD,

DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.

H-405.969 – "Definition of a Physician", states:

> … a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.
>
> AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

Code of Medical Ethics

The Code already addresses transparency in context of residents and fellows. Opinion 9.2.2, "Resident & Fellow Physicians' Involvement in Patient Care," possesses some language regarding transparency and identification where it states:

> When they are involved in patient care, residents and fellows should:
>
> (a) Interact honestly with patients, including clearly identifying themselves as members of a team that is supervised by the attending physician and clarifying the role they will play in patient care.

In the context of a team-based collaborative care involving nonphysician practitioners, Opinion 10.8, "Collaborative Care" is the most relevant *Code* opinion. It gives guidance on the collaborative team-based setting, where a mix of health professionals provide care. However, Opinion 10.8 lacks guidance on the transparency of identification and credentials, ultimately leaving the *Code* silent on the issue of transparency in the context of team-based collaborative care. Hence, amendment to Opinion 10.8 is warranted.

RECOMMENDATION

In light of the foregoing, the Council on Ethical and Judicial Affairs recommends that Opinion 10.8, Collaborative Care be amended as follows and the remainder of this report be filed:

> In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, protecting and promoting the integrity of the patient-professional ~~physician~~ relationship, sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.
>
> Health care teams often include members of multiple health professions, including physicians, nurse practitioners, physician assistants, pharmacists, physical therapists, and care managers among others. To foster the trust essential to patient-professional relationships, all members of the team should be candid about their professional credentials, their experience, and the role they will play in the patient's care.

An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

As clinical leaders within health care teams, physicians individually should:

(a) Model ethical leadership by:

(i) Understanding the range of their own and other team members' skills and expertise and roles in the patient's care
(ii) Clearly articulating individual responsibilities and accountability
(iii) Encouraging insights from other members and being open to adopting them and
(iv) Mastering broad teamwork skills

(b) Promote core team values of honesty, discipline, creativity, humility and curiosity and commitment to continuous improvement.

(c) Help clarify expectations to support systematic, transparent decision making.

(d) Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member's opinion is heard and considered and team members share accountability for decisions and outcomes.

(e) Communicate appropriately with the patient and family, including being forthright when describing their profession and role, and respecting the unique relationship of patient and family as members of the team.

As leaders within health care institutions, physicians individually and collectively should:

(f) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.

(g) Encourage their institutions to identify and constructively address barriers to effective collaboration.

(h) Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care.

(i) Promote a culture of respect, collegiality and transparency among all health care personnel.

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 3-A-22

Subject: Amendment to E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment"

Presented by: Alexander M. Rosenau, DO, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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INTRODUCTION

At the November 2021 Special Meeting, the American Medical Association House of Delegates adopted Policy D-140.952, "AMA Council on Ethical and Judicial Affairs Report on Physician Responsibilities to Impaired Colleagues," asking the Council to consider specific amendments to guidance adopted by the House at its June 2021 Special Meeting as follows:

(i) Advocating for supportive services, <u>including physician health programs,</u> and accommodations to enable physicians <u>and physicians-in-training</u> who require assistance to provide safe, effective care.

with additional guidance

<u>(k) Advocating for fair, objective, external, and independent evaluations for physicians when a review is requested or required to assess a potential impairment and its duration by an employer, academic medical center, or hospital/health system where said physician has clinical privileges or where said physician-in training is placed for a clinical rotations.</u>

The Council thanks the House for offering these clarifications and fully concurs with the importance of ensuring fair assessment of any potential impairment.

RECOMMENDATION

The Council believes that a more general formulation that did not delineate specific actors would better emphasize the importance of fairness whenever and by whomever such assessment is sought and would help ensure that guidance remains evergreen. The Council therefore proposes to amend Opinion 9.3.2 by insertion as follows:

E-9.3.2 – Physician Responsibilities to Colleagues with Illness, Disability or Impairment

Providing safe, high-quality care is fundamental to physicians' fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions—including physical disability, medical illness, and substance use—can undermine physicians' ability to fulfill that

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obligation. These conditions in turn can put patients at risk, compromise physicians' relationships with patients, as well as colleagues, and undermine public trust in the profession.

While some conditions may render it impossible for a physician to provide care safely, with appropriate accommodations or treatment many can responsibly continue to practice, or resume practice once those needs have been met. In carrying out their responsibilities to colleagues, patients, and the public, physicians should strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly.

As individuals, physicians should:

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

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

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

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

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

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

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

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

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

(i) Advocating for supportive services, including physician health programs, and accommodations to enable physicians and physicians-in-training who require assistance to provide safe, effective care.

(j) Advocating for respectful and supportive, evidence-based peer review policies and practices to ensure fair, objective, and independent assessment of potential impairment whenever and by whomever assessment is deemed appropriate to~~that will~~ ensure patient safety and practice competency. (II)

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 4-A-22

Subject: CEJA's Sunset Review of 2012 House Policies

Presented by: Alexander M. Rosenau, DO, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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

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

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

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

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

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

Fiscal Note: Less than $500.

APPENDIX - RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-478.978	Electronic Health Record "Lemon Law"	Our AMA will pursue possibilities, consistent with our strategic direction and existing guidelines for working with third parties, to develop tools, accessible to all AMA members, which can help physicians in the selection and evaluation of electronic health records. (BOT Rep. 9, A-12)	Retain; remains relevant.
D-85.995	Medical Examiner Patient Postmortem: Cause of Death Transparency	Our AMA will: (1) convene a study group to examine strategies to implement a postmortem process or standard for ongoing communication between the medical examiner, physicians, health care providers, and family members; and (2) develop guidelines for hospital processes for communication between medical examiners, clinicians, families, medical staffs, and other key stakeholders to establish a postmortem management methodology that includes timely communication between all parties. (Res. 726, A-12)	Rescind; directive was fulfilled. A study group was convened and resultant guidelines can be found here.
H-235.977	Medical Staff Committees to Assist Impaired or Distressed Physicians	Our AMA recognizes the importance of early recognition of impaired or distressed physicians, and encourages hospital medical staffs to have provisions in their bylaws for a mechanism to address the physical and mental health of their medical staff and housestaff members. (Sub. Res. 67, A-89; Reaffirmed: BOT Rep. 17 and Sunset Report, A-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12)	Retain; remains relevant.
H-370.971	Increasing Organ Donation	Our AMA recognizes the importance of physician participation in the organ donation process and acknowledges organ donation as a specialized form of end-of-life care. (CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain; remains relevant.
H-370.975	Ethical Issues in the Procurement of Organs Following Cardiac Death	The Pittsburgh Protocol: The following guidelines have been adopted: The Pittsburgh protocol, in which organs are removed for transplantation from patients who have had life-sustaining treatment withdrawn, may be ethically acceptable and should be pursued as a pilot project. The pilot project should (1) determine the protocol's acceptability to the public, and (2) identify the number and usability of organs that may be procured through this approach. The protocol currently has provisions for limiting conflicts of interest and ensuring voluntary consent. It is critical that the health care team's conflict of interest in caring for potential donors at the end of life be minimized, as the protocol currently provides, through maintaining the	Rescind; while the policy remains relevant, it has been superseded by formal ethics policy at Opinion 6.1.2 – "Organ Donation After Cardiac Death."

		separation of providers caring for the patient at the end of life and providers responsible for organ transplantation. In addition to the provisions currently contained in the protocol, the following additional safeguards are recommended: (a) To protect against undue conflicts of interest, the protocol should explicitly warn members of the health care team to be sensitive to the possibility that organ donation decisions may influence life-sustaining treatment decisions when the decisions are made by surrogates. Further, if there is some reason to suspect undue influence, then the health care team members should be required, not merely encouraged, to obtain a full ethics consultation. (b) The recipients of organs procured under the Pittsburgh protocol should be informed of the source of the organs as well as any potential defects in the quality of the organs, so that they may decide with their physicians whether to accept the organs or wait for more suitable ones. (c) Clear clinical criteria should be developed to ensure that only appropriate candidates, whose organs are reasonably likely to be suitable for transplantation, are considered eligible to donate organs under the Pittsburgh protocol. (CEJA Rep. 4 - I-94; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed:CEJA Rep. 3, A-12)	
H-370.982	Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients	Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered. (2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All	Retain; remains relevant. Policy is further complimented by ethics policy at Opinion 11.1.3 – "Allocating Limited Health Care Resources."

		candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula. (3) Decision making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions. (4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision. (5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession. (6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them. (7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means. (CEJA Rep. K, A-93; Reaffirmed: CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 6, A-00; Appended: Res. 512, A-02; Reaffirmed:CEJA Rep. 3, A-12)	
H-370.983	Tissue and Organ Donation	Our AMA will assist the United Network for Organ Sharing in the implementation of their recommendations through broad-based physician and patient education. (Res. 533, A-92; Reaffirmed: CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain; remains relevant.

H-370.986	Donor Tissues and Organs for Transplantation	The AMA strongly urges physicians or their designees to routinely contact their hospital's designated tissue or organ procurement agency (as appropriate), at or near the time of each patient's death, to determine the feasibility of tissue and/or organ donation. (Res. 103, I-90; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain; remains relevant.
H-370.990	Transplantable Organs as a National Resource	Our AMA: (1) supports the United Network of Organ Sharing (UNOS) policy calling for regional allocation of livers to status 1 (most urgent medical need) patients as an effort to more equitably distribute a scarce resource; (2) opposes any legislation, regulations, protocols, or policies directing or allowing governmental agencies to favor residents of a particular geo-political jurisdiction as recipients of transplantable organs or tissues; (3) reaffirms its position that organs and tissues retrieved for transplantation should be treated as a national, rather than a regional, resource; and (4) supports the findings and recommendations of the Institute of Medicine Committee on Organ Procurement and Transplantation Policy. (Res. 94, I-87; Reaffirmed: Sunset Report, I-97; Appended and Reaffirmed CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain; remains relevant.
H-370.995	Organ Donor Recruitment	Our AMA supports development of "state of the art" educational materials for the medical community and the public at large, demonstrating at least the following: (1) the need for organ donors; (2) the success rate for organ transplantation; (3) the medico-legal aspects of organ transplantation; (4) the integration of organ recruitment, preservation and transplantation; (5) cost/reimbursement mechanisms for organ transplantation; and (6) the ethical considerations of organ donor recruitment. (Res. 32, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain; remains relevant.
H-370.998	Organ Donation and Honoring Organ Donor Wishes	Our AMA: (1) continues to urge the citizenry to sign donor cards and supports continued efforts to educate the public on the desirability of, and the need for, organ donations, as well as the importance of discussing personal wishes regarding organ donation with appropriate family members; and (2) when a good faith effort has been made to contact the family, actively	Retain; remains relevant.

		encourage Organ Procurement Organizations and physicians to adhere to provisions of the Uniform Anatomical Gift Act which allows for the procurement of organs when the family is absent and there is a signed organ donor card or advanced directive stating the decedent's desire to donate the organs. (CSA Rep. D, I-80; CLRPD Rep. B, I-90; Amended: Res. 504, I-99; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(A-22)

Introduced by: Young Physicians Section

Subject: Increasing Public Umbilical Cord Blood Donations in Transplant Centers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Allogeneic stem cell transplants continue to save lives, reaching over 20,000 procedures per year in the United States[1]; and

Whereas, Allogeneic stem cell therapy can only save lives in patients matched with a donor; and

Whereas, Umbilical cord blood stem cells offer clinical advantages over traditional stem cell transplants in select scenarios[2]; and

Whereas, Umbilical cord blood transplants increase the ethnic diversity of patients eligible for transplant[3]; and

Whereas, The American Society for Transplantation and Cellular Therapy[4], the American College of Obstetricians and Gynecologists[5], and the American Academy of Pediatrics[6] all support public (altruistic) donation of cord blood when possible; and

Whereas, Public donation of cord blood is difficult if the birthing hospital does not support public cord donation; and

Whereas, Very few hospitals support in-house public cord blood donation infrastructure - only two hospitals in Ohio, and three each in New York and Massachusetts[7]; and

Whereas, Many hospitals which provide comprehensive care including both childbirths and stem cell transplants are notably absent from these lists; therefore be it

RESOLVED, That our American Medical Association encourage all hospitals with obstetrics programs to make available to patients and reduce barriers to public (altruistic) umbilical cord blood donation (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the availability of altruistic cord blood donations in all states. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/17/22

References:
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2. The Leukemia & Lymphoma Society. Cord Blood Stem Cell Transplantation. 2 Aug 2007. Available at https://www.lls.org/sites/default/files/file_assets/cordbloodstemcelltransplantation.pdf.
3. Be the Match. Cord blood donation frequently asked questions. Accessed 22 Apr 2019. Available at https://bethematch.org/support-the-cause/donate-cord-blood/cord-blood-faqs/.
4. American Society for Blood and Marrow Transplantation. ASBMT POSITION STATEMENT Collection and Preservation of Cord Blood for Personal Use. Biology of Blood and Marrow Transplantation 14:364 (2008). Available at https://higherlogicdownload.s3.amazonaws.com/ASBMT/43a1f41f-55cb-4c97-9e78-c03e867db505/UploadedImages/ASBMT_Cord_Blood_Position_Statement.pdf.
5. American College of Obstetricians and Gynecology. ACOG Committee Opinion Number 771. 21 Feb 2019. Available at https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Genetics/Umbilical-Cord-Blood-Banking.
6. Section on Hematology/Oncology and Section on Allergy/Immunology, American Academy of Pediatrics. Cord Blood Banking for Potential Future Transplantation. Pediatrics Jan 2007, 119 (1) 161-164; DOI: 10.1542/peds.2006-2900. Available at https://pediatrics.aappublications.org/content/pediatrics/119/1/165.full.pdf.
7. Be the Match. List of Participating Hospitals. Accessed 22 Apr 2019. Available at https://bethematch.org/support-the-cause/donate-cord-blood/how-to-donate-cord-blood/participating-hospitals/.

RELEVANT AMA POLICY

Code of Medical Ethics. 6.1.5 Umbilical Cord Blood Banking

Transplants of umbilical cord blood have been recommended or performed to treat a variety of conditions. Cord blood is also a potential source of stem and progenitor cells with possible therapeutic applications. Nonetheless, collection and storage of cord blood raise ethical concerns with regard to patient safety, autonomy, and potential for conflict of interest. In addition, storage of umbilical cord blood in private as opposed to public banks can raise concerns about access to cord blood for transplantation.

Physicians who provide obstetrical care should be prepared to inform pregnant women of the various options regarding cord blood donation or storage and the potential uses of donated samples.

Physicians who participate in collecting umbilical cord blood for storage should:

(a) Ensure that collection procedures do not interfere with standard delivery practices or the safety of a newborn or the mother.

(b) Obtain informed consent for the collection of umbilical cord blood stem cells before the onset of labor whenever feasible. Physicians should disclose their ties to cord blood banks, public or private, as part of the informed consent process.

(c) Decline financial or other inducements for providing samples to cord blood banks.

(d) Encourage women who wish to donate umbilical cord blood to donate to a public bank if one is available when there is low risk of predisposition to a condition for which umbilical cord blood cells are therapeutically indicated:

(i) in view of the cost of private banking and limited likelihood of use;

(ii) to help increase availability of stem cells for transplantation.

(e) Discuss the option of private banking of umbilical cord blood when there is a family predisposition to a condition for which umbilical cord stem cells are therapeutically indicated.

(f) Continue to monitor ongoing research into the safety and effectiveness of various methods of cord blood collection and use.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(A-22)

Introduced by: New York

Subject: Opposition to Discriminatory Treatment of Haitian Asylum Seekers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, The United States has sought to provide asylum for individuals being persecuted in
2 other countries and has instituted laws and policies to achieve this goal equitably for all peoples
3 of the world; and
4
5 Whereas, Haitians seeking asylum have often experienced discrimination in seeking asylum
6 because of the inaccurate media narrative of an association of AIDS to Haitians; and
7
8 Whereas, The CDC in 1990 changed its policy on AIDS and Haitians thus removing the false
9 narrative on AIDS and Haitians; and
10
11 Whereas, Haitians seeking asylum in the United States continue to experience adverse
12 outcomes in their applications for asylum based on inaccurate narratives and media bias; and
13
14 Whereas, Recent activities at the US border with Mexico have focused heavily on denying entry
15 to Haitians seeking escape from the violence in their native country and returning them to Haiti;
16 and
17
18 Whereas, Our AMA has many policy statements on health disparities, racial discrimination and
19 equality but no policy specific to the matter adversely affecting Haitian asylum seekers;
20 therefore be it
21
22 RESOLVED, That our American Medical Association oppose discrimination against Haitian
23 asylum seekers which denies them the same opportunity to attain asylum status as individuals
24 from other nations. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 03/22/22

RELEVANT AMA POLICY

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(A-22)

Introduced by: Women Physicians Section

Subject: Gender Equity and Female Physician Work Patterns During the Pandemic

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Studies show that women carry more responsibility than their male counterparts for personal and family life[1, 3]; and

Whereas, A study following a cohort of faculty from the 1995 National Faculty Survey through 17 years showed persistent gender disparities in rank, retention, and leadership positions;[2] and

Whereas, Prior to the pandemic, due to the culture of medicine, many female physicians made adjustments in their professional roles, including "part-time status, despite the known limitations on professional progression, career advancement, and economic potential. These adjustments further propagate gender inequities and the persistent compensation gap female physicians experience;"[3] and

Whereas, The COVID-19 pandemic is requiring additional adjustments to the professional lives of physicians and many of these adjustments will be made disproportionately by female physicians due to childcare and pregnancy;[4] and

Whereas, Since the pandemic, there has been a decrease in the percentage of physicians working full-time, a rise in the percentage who were laid off, and an increase in changes in physicians' usual activities. The decline in the percentage of parents with preschool-aged children among only female physicians may suggest a disproportionate uptake of childcare responsibilities among female physicians;[5] and

Whereas, In a recent survey, female scientists reported a decline in research time relative to male colleagues during the COVID-19 pandemic, but the most significant factor was having a young dependent less than 6 years of age;[6] and

Whereas, One in five physicians experienced a financial cut or furlough because of the pandemic, but there is limited data on how these cuts and furloughs have impacted female physicians specifically[7]; therefore be it

RESOLVED, That our American Medical Association advocate for research on physician-specific data analyzing changes in work patterns and employment outcomes among female physicians during the pandemic including, but not limited to, understanding potential gaps in equity, indications for terminations and/or furloughs, gender differences in those who had unpaid additional work hours, and issues related to intersectionality (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with relevant organizations to evaluate obstacles affecting female physicians and medical students during the pandemic. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 03/31/22

References:

1. Jolly S, Griffith KA, DeCastro R, Stewart A, Ubel P, Jagsi R. Gender differences in time spent on parenting and domestic responsibilities by high-achieving young physician-researchers. Ann Intern Med. 2014;160(5):344-353.
2. Carr PL, Raj A, Kaplan SE, Terrin N, Breeze JL, Freund KM. Gender differences in academic medicine: Retention, rank, and leadership comparisons from the National Faculty Survey. Acad Med. 2018;93(11):1694-1699.
3. Jena AB, Olenski AR, Blumenthal DM. Sex differences in physician salary in US public medical schools. *JAMA Intern Med*. 2016;176(9):1294-1304. doi:10.1001/jamainternmed.2016.3284
4. Brubaker L. Women Physicians and the COVID-19 Pandemic. *JAMA*. 2020;324(9):835–836. doi:10.1001/jama.2020.14797
5. Hu X, Dill MJ. Changes in Physician Work Hours and Patterns During the COVID-19 Pandemic. *JAMA Netw Open.* 2021;4(6):e2114386.
6. Myers K.R., Tham W.Y., Yin Y. Unequal effects of the COVID-19 pandemic on scientists. *Nat Human Behav*. 2020;4:880–883.
7. Paavola, A., 1 in 5 physicians hit with high pay cuts or furlough due to COVID-19, survey says. Beck Hospital review. April 22, 2020. www.beckerhospitalreview.com

RELEVANT AMA POLICY

Principles for Advancing Gender Equity in Medicine H-65.961

Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.
Citation: BOT Rep. 27, A-19

AMA Principles for Physician Employment H-225.950

1. Addressing Conflicts of Interest

a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.

c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and

(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.

e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession

a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.
Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any

matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.
Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
(f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
i. The agreement is for the provision of services on an exclusive basis; and
ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.
Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

Citation: BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(A-22)

Introduced by: Medical Student Section

Subject: Recognizing LGBTQ+ Individuals as Underrepresented in Medicine

Referred to: Reference Committee Amendments to Constitution and Bylaws

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1 Whereas, The Association of American Medical Colleges (AAMC) has defined
2 underrepresented minorities (URMs) in medicine as "racial and ethnic populations that are
3 underrepresented in the medical profession relative to their numbers in the general population"
4 since 2003, with an overarching goal to advocate for population parity[1]; and
5
6 Whereas, The AAMC 2016 Report on Diversity in Medical Education noted that considering
7 diversity as referring solely to race and ethnicity is too narrow and that broadening the definition
8 of diversity would help to encompass sexual orientation, religion, geography, disability, age,
9 language, and gender identity[2]; and
10
11 Whereas, The acronym LGBTQ+ is an umbrella term encompassing people who identify their
12 sexual orientation as lesbian, gay, bisexual and/or who identify their gender identify as
13 transgender; the last two components of the acronym can stand for queer or questioning and
14 are meant to encompass all identities that are not heterosexual or cisgender[3]; and
15
16 Whereas, Individuals can belong to the LGBTQ+ community by virtue of their sexual orientation,
17 gender identity, or both of these identity aspects[3-5]; and
18
19 Whereas, The National Institutes of Health (NIH) formally designated sexual and gender
20 minorities (SGMs) as a health disparity population for NIH research due to mounting evidence
21 that SGM populations have less access to healthcare and higher burdens of diseases such as
22 depression, cancer, and HIV/AIDS[6]; and
23
24 Whereas, In 2015, a study in *The American Journal of Public Health* showed the majority of
25 heterosexual healthcare providers reported moderate to strong implicit preference for
26 heterosexual patients over homosexual patients, while gay and lesbian providers showed more
27 implicit preference in favor of homosexual patients[7]; and
28
29 Whereas, In 2015, the American College of Physicians emphasized the need for "programs that
30 would help recruit LGBT[Q+] persons into the practice of medicine and programs that offer
31 support to LGBT medical students, residents, and practicing physicians"[8]; and
32
33 Whereas, Two-thirds of LGBT physicians have heard disparaging remarks about LGBTQ+
34 people at work, one-third have witnessed discriminatory care of a LGBT patient, and one-fifth
35 have experienced social ostracism because of their LGBTQ+ identity[9]; and

Whereas, Data on LGBTQ+ individuals in medicine are limited due to their self-reported nature and fear of disclosure, with the AAMC's 2018 *All Schools Summary Reports* including a caveat in the methodology that demographic data may not be generalizable[10-12]; and

Whereas, The AAMC's *Reports on Diversity and Inclusion* assert that "a nuanced diversity and inclusion data collection and analysis strategy will allow for a more accurate understanding of underrepresented groups in medicine"[13]; therefore be it

RESOLVED, That our American Medical Association advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident, and provider diversity(Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured (New HOD Policy); and be it further

RESOLVED, That our AMA work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities. (Directive to Take Action)

Fiscal note: Moderate - between $5,000 - $10,000

Date received: 04/08/22

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RELEVANT AMA POLICY:

Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools D-295.322
Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity.
Citation: Res. 313, A-09; Modified: CME Rep. 6, A-11; Reaffirmed: CME Rep. 1, A-21

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.
Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21

Medical Staff Development Plans H-225.961
All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria related to appointment/reappointment

to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used .inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, gender identity or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals.
Citation: BOT Rep. 14, A-98; Modified: BOT Rep. 11, A-07; Reaffirmation A-10; Modified: CMS Rep. 01, A-20

Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878
Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education.
Citation: Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16; Modified: Res. 16, A-18; Modified: Res. 302, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(A-22)

Introduced by: Medical Student Section

Subject: Supporting the Study of Reparations as a Means to Reduce Racial Inequalities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Many healthcare disparities that exist today can be attributed to exploitative structural policies targeting minorities, especially the Black community, including disproportionate rates of incarceration,[5–7] residential segregation,[8] and unfair labor and employment policies; [1–4] and

Whereas, Toxic stresses of racism, incarceration, community violence, and low socioeconomic status are shown to increase the likelihood of social/emotional/cognitive impairment, high-risk behavior[10], disease, and early death in minority children[9, 11,12]; and

Whereas, The racial wealth gap in the United States has increased dramatically, as households with Black children hold just one cent for every dollar held by households with non-Hispanic White children as of 2016[13,14]; and

Whereas, Income has been shown to be positively correlated with life expectancy, increased access to care, and improved health outcomes[15,16]; and

Whereas, Effects of Jim Crow era policies throughout time have severely hindered access to education and job opportunities, which are correlated with positive health outcomes, for the African American community[17,18,19,20]; and

Whereas, The United States has never created a commission to formally study the health, economic or social impacts of slavery and the Jim Crow era on African Americans and the resolution of those injustices through the context of reparations[14,21]; and

Whereas, Reparations, encompassing a broad variety of public aid including but not limited to direct compensation, special education and job training, and community support for descendants of slaves, have been discussed as a means to support the marginalized Black community and end multi-generational poverty and its associated racial inequities[21]; and

Whereas, In 2015, Chicago became the first city in the United States to propose reparations for victims of police torture and brutality, in a measure including $5.5 million in direct compensation, free college education to survivors, a formal apology from the city, and education on police torture in public schools[22]; and

Whereas, Reparations are designed to promote intergenerational wealth amongst affected communities, which in turn will increase the health outcomes of these communities; and

Whereas, Legislators have unsuccessfully introduced House Resolution 40: “Commission to Study Reparation Proposals for African Americans Act,” which asked for a study of reparations, into Congress every year since 1989[14,21,23]; and

Whereas, Individual cities and states including in California, Illinois, and North Carolina among others, are now beginning to adopt policies acknowledging a need for reparations to address racial disparities resulting in adverse health outcomes[23–25]; and

Whereas, Countries such as South Africa, which developed a Truth and Reconciliation Commission to address its history of apartheid, and France, which approved over $60 million in 2014 to be allocated to Holocaust survivors and their descendants, have implemented reparations successfully in the past[26,27]; and

Whereas, The United Nations and many of its member nations have created commissions repeatedly calling for reparations in the United States and for lawmakers to pass HR 40 or similar legislation[28-30]; and

Whereas, Reparations may serve as an avenue to alleviate some of the health, educational, and economic disparities faced by the US Black population[14,30,31]; and

Whereas, The Black community is severely underrepresented in medicine, due to many societal barriers for success and the closure of all but two predominantly Black medical schools after the 1910 publication of the Flexner Report[31]; and

Whereas, The AMA historically refused to establish a policy of nondiscrimination or take action against AMA-affiliated state and local medical associations that openly practiced racial exclusion in their memberships[32,33]; and

Whereas, AMA President-Emeritus Dr. Ronald Davis issued an apology on behalf of the AMA for its past wrongs and pushed the AMA towards continually addressing health disparities alongside all public health and health care stakeholders[33]; therefore be it

RESOLVED, That our American Medical Association study potential mechanisms of national economic reparations that could improve inequities associated with institutionalized, systematic racism and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA study the potential adoption of a policy of reparations by the AMA to support the African American community currently interfacing with, practicing within, and entering the medical field and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA support federal legislation that facilitates the study of reparations. (New HOD Policy)

Fiscal Note: Estimated cost to implement resolution is $110,000.

Date Received: 04/08/22

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RELEVANT AMA POLICY

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

AMA Initiatives Regarding Minorities H-350.971
The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components: (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine; (2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities; (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities; (4) Response to inquiries and concerns of minority physicians and medical students; and (5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.
CLRPD Rep. 3, I-98; CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20

Improving the Health of Black and Minority Populations H-350.972
Our AMA supports: (1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities. (2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health. (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities. (4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.
CLRPD Rep. 3, I-98; Reaffirmation: A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 1, A-21

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation: A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(A-22)

Introduced by: Medical Student Section

Subject: Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Natural hair can be defined as a hair texture that is tightly coiled or tightly curled as well as hairstyles that include locs, cornrows, twists, braids, Bantu knots, fades, Afros, and/or the right to keep hair in an uncut or untrimmed manner [1]; and

Whereas, Cultural headwear refers to head or hair coverings (i.e. hijabs, turbans) worn for cultural purposes and serves as a way to express values of a demographic group or particular society for religious, spiritual, or gender identification [2]; and

Whereas, Discrimination and/or restrictions targeting hairstyles and/or headwear are proxies for racial, ethnic, and/or religious discrimination since hair textures and styles, along with cultural headwear, are phenotypic features used in categorizing race, ethnicity, and/or religious association [3-6]; and

Whereas, Title VII of the 1964 Civil Rights Act states it is unlawful for employers to discriminate against any individual based on an "... individual's race, color, religion, sex, or national origin," and section 703(a) of Title VII mentions prohibiting not only intentional discrimination, but also unintentional discrimination on the enumerated proscribed ground [7]; and

Whereas, Appearance guidelines, in the form of "race-neutral" grooming policies, used as part of medical professionalism standards tend to be euro-centric and penalize those with non-euro-centric phenotypical features and/or culture [8,9]; and

Whereas, In 2019, the State of California and New York City passed laws to address hair discrimination within the workplace through the CROWN Act (SB 188) and the NYC Commission on Human Rights Legal Enforcement Guidance on Race Discrimination on the Basis of Hair [1,3]; and

Whereas, United States Armed Forces have repealed several bans on natural hair and cultural headwear in the workplace (Army Regulation 670-1, Section 3-2) [10]; and

Whereas, Qualitative analysis of minority resident physicians has revealed the additional challenges to embracing their racial identities in a professional setting results in less job satisfaction and more susceptibility to burnout [11]; and

Whereas, Studies show "a positive association between physician-patient racial/ethnic concordance and patients' receiving preventive care, being satisfied with their care overall..." [12]; and

Whereas, The AMA has policies (H-295.955, H-310.919, H-310.923, D-350.984) focused on combating racial, ethnic, and religious discrimination in medicine, but fails to include discrimination against natural hair and cultural headwear as a form of racial, ethnic, and religious discrimination; therefore be it

RESOLVED, That our American Medical Association recognize that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination (New HOD Policy); and be it further

RESOLVED, That our AMA oppose discrimination against individuals based on their hair or cultural headwear in health care settings (New HOD Policy); and be it further

RESOLVED, That our AMA acknowledge the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace (New HOD Policy); and be it further

RESOLVED, That our AMA encourage medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 04/08/22

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RELEVANT AMA POLICY

Principles for Advancing Gender Equity in Medicine H-65.961

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;

5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.
Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.
BOT Rep. 27, A-19

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
CCB/CLRPD Rep. 3, A-14,Reaffirmed in lieu of: Res. 001, I-16,Reaffirmation: A-17

Teacher-Learner Relationship In Medical Education H-295.955
The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR
The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling. Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.

BOT Rep. ZZ, I-90,Reaffirmed by CME Rep. 9, A-98,Reaffirmed: CME Rep. 2, I-99,Modified: BOT Rep. 11, A-07,Reaffirmed: CME Rep. 9, A-13; Reaffirmed: BOT Rep. 9, I-20

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919

Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;

2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.
Res. 307, A-09, Appended: Res. 955, I-17

Eliminating Religious Discrimination from Residency Programs H-310.923
Our AMA encourages residency programs to: (1) make an effort to accommodate residents' religious holidays and observances, provided that patient care and the rights of other residents are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious holidays and observances.
CME Rep. 10, A-06, Reaffirmed: CME Rep. 01, A-16

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.
BOT Action in response to referred for decision: Res. 602, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(A-22)

Introduced by: Medical Student Section

Subject: Equal Access to Adoption for the LGBTQ Community

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Current federal qualifications for adoption, according to U.S. Citizenship and Immigration Services (USCIS) are as follows:

1. You must be a U.S. Citizen.
2. If you are unmarried, you must be at least 25 years old.
3. If you are married, you must jointly adopt the child (even if you are separated but not divorced), and your spouse must also be either a U.S. citizen or in legal status in the United States.
4. You must meet certain requirements that will determine your suitability as a prospective adoptive parent, including criminal background checks, fingerprinting, and a home study[1]; and

Whereas, The federal government currently allocates funding for adoption and foster care to states, which independently manage federal funds and have differing statutes concerning eligibility to adopt or place a child up for adoption[2-4.]; and

Whereas, Independent state-licensed child welfare agencies are contracted by each state to provide foster care or adoption services[5]; and

Whereas, The American Bar Association recently adopted a resolution in 2019 criticizing how "state-sanctioned discrimination against LGBT individuals who wish to raise children has dramatically increased in recent years"[6-7]; and

Whereas, Eleven states currently permit state-licensed welfare agencies to refuse placement of children with LGBTQ individuals and same-sex couples and fourteen additional states lack explicit protection for LGBTQ individuals concerning adoption rights[5]; and

Whereas, In fiscal year 2018 alone, the need for adoption was evident as there were 437,283 total children in the U.S. foster care system with 125,422 children waiting to be adopted[8]; and

Whereas, According to 2019 Adoption and Foster Care Analysis and Reporting System (AFCARS) data, 58% or 143,572 children spent over 12 months in foster care before leaving the system[8]; and

Whereas, The longer a child is in foster care, the more likely that child is to move from one foster placement to another, and the greater the risk that child experiences adverse childhood events (ACEs), which may result in lasting negative social and emotional consequences[9]; and

Whereas, Per evaluation with the Child Behavior Checklist (CBCL), children who enter foster care with no known internal or external problems show an increase in “total problem behavior” in direct correlation with their number of placements[10-12]; and

Whereas, Frequent placement changes result in difficulty forming secure attachments with foster parents, low self-esteem, and a negative relationship with academic growth[10-12]; and

Whereas, Per the Centers for Disease Control and Prevention, “Creating and sustaining safe, stable, nurturing relationships and environments for all children and families can prevent ACEs and help all children reach their full potential”[13]; and

Whereas, Recent social science literature supports that children living with same-sex parents have equivalent outcomes compared to children with different-sex parents[14]; and

Whereas, Estimates from the 2010 U.S. Census suggest there are nearly 650,000 same-sex couples living in the U.S., and same-sex couples are five times (10% vs 2%) more likely to adopt children under age 18 compared to different sex couples[15-16]; and

Whereas, Current AMA Policy H-60.959 calls for the “comprehensive and evidence-based care that addresses the specific health care needs of children in foster care” and supports the "best interest of the child" as the most important criterion determining custody, placement, and adoption of children;” and

Whereas, AMA policy H-60.940 supports the rights of a non-married partner to adopt the child of their co-parenting partner but does not adequately address adoption rights of LGBTQ individuals nor their limited eligibility or access to adoption, allowing for potential harm towards children by narrowing the pool of qualified foster and adoptive homes; therefore be it

RESOLVED, That our American Medical Association advocate for equal access to adoption services for LGBTQ individuals who meet federal criteria for adoption regardless of gender identity or sexual orientation (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage allocation of government funding to licensed child welfare agencies that offer adoption services to all individuals or couples including those with LGBTQ identity. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 04/08/22

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RELEVANT AMA POLICY

Uniformity of State Adoption and Child Custody Laws H-60.959

The AMA urges: (1) state medical societies to support the adoption of a Uniform Adoption Act that places the best interest of the child as the most important criteria; (2) the National Conference of Commissioners on Uniform State Laws to include mandatory pre-consent counseling for birth parents as part of its proposed Uniform Adoption Act; and (3) state medical societies to support adoption of child custody statutes that place the "best interest of the child" as the most important criterion determining custody, placement, and adoption of children.
Sub. Res. 219, I-93Reaffirmed: BOT Rep. 28, A-03Reaffirmed: BOT Rep. 28, A-13

Addressing Healthcare Needs of Children in Foster Care H-60.910

Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.
Res. 907, I-17

Partner Co-Adoption H-60.940

Our AMA will support legislative and other efforts to allow the adoption of a child by the non-married partner who functions as a second parent or co-parent to that child.
Res. 204, A-04; Modified: CSAPH Rep. 1, A-14

Health Care disparities in Same-Sex Partner Households H-65.973

Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.
CSAPH Rep. 1, I-09; BOT Action in response to referred for decision; Res. 918, I-09; Reaffirmed in lieu of Res. 918, I-09; BOT Rep. 15, A-11; Reaffirmed in lieu of Res. 209, A-12

Adoption H-420.973
It is the policy of the AMA to (1) support the provision of adoption information as an option to unintended pregnancies; and (2) support and encourage the counseling of women with unintended pregnancies as to the option of adoption.
Res. 146, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(A-22)

Introduced by: Medical Student Section

Subject: Student-Centered Approaches for Reforming School Disciplinary Policies

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, School-related arrests and juvenile justice referrals have been associated with school disengagements, lower graduation rates, increased dropout rates, and increased involvement in the school-to-prison pipeline[1, 2]; and

Whereas, School-related arrests and juvenile justice referrals disproportionately target Black students, Latinx students, male students, and students with physical or mental disabilities[3, 4, 5]; and

Whereas, Research on the effectiveness of school resource officer programs is limited, and fails to make a strong case for harsh discipline programs that include referral to law enforcement[6]; and

Whereas, School-based mental health efforts have been successful in identifying those in need of mental health services, bolstering academic functioning, and improving patterns of behavior[7]; and

Whereas, Educators, nurses, and counselors can play a key role in fostering protective environments for children and identifying students who may need additional support, in contrast to school resource officers[8, 9]; and

Whereas, School-based mental health professionals report ever-increasing workloads and responsibilities that include disciplinary roles[10, 11]; and

Whereas, Students report feeling hesitant to approach counselors to discuss academic, mental health, or social issues because they do not feel that their disclosure will be kept private, possibly affecting their academic or conduct standing[12]; and

Whereas, The American School Counselor Association urges that “school counselors maintain non-threatening relationships with students to best promote student achievement and development” and states that school counselors are neither “disciplinarians” or “enforcement agent[s] for the school”[13]; and

Whereas, The National Association of School Nurses states that school nurses should facilitate an “environment that values connecting students, families, and the community in positive engagement” characterized by “safety and trust where students are aware that caring, trained adults are present and equipped to take action on their behalf”[14]; and

Whereas, Positive Behavior Interventions and Supports (PBIS) is an evidence-based implementation framework focusing on prevention and intervention strategies that support the academic, social, emotional, and behavioral competence of students at all levels of education[15]; and

Whereas, PBIS promotes prevention of student misbehavior by having students experience "predictable instructional consequences for problem behavior without inadvertent rewarding" while educators provide "clear and predictable consequences for problem behavior and following up with constructive support to reduce the probability of future problem behavior"[15]; and

Whereas, PBIS was shown in a group randomized controlled effectiveness trial of 12,344 elementary students to reduce concentration and behavioral problems, and increase social-emotional functioning and prosocial behavior[16]; and

Whereas, PBIS implementation has been linked to positive outcomes in attendance, behavior, and academics while decreasing office discipline referrals, in-school suspensions, and out-of-school suspensions[17, 18]; and

Whereas, Mental Health America and the American Academy of Pediatrics have recognized the detrimental effects of “zero tolerance” policies and have advocated for school wide PBIS as an alternative[19, 20]; and

Whereas, AMA policy H-60.919 includes support for “school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments,” but is largely focused on determination of punishment rather than prevention of misbehavior; and

Whereas, AMA policy H-60.991 establishes the role of school-based health programs and AMA policy H-60.902 addresses the need for policy ensuring proper qualification and training for school resource officers, but do not delineate if or how school-based health professionals should participate in school disciplinary roles; therefore be it

RESOLVED, That our American Medical Association support evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior (New HOD Policy); and be it further

RESOLVED, That our AMA support the inclusion of school-based mental health professionals in the student discipline process. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 04/08/22

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RELEVANT AMA POLICY

Juvenile Justice System Reform, H-60.919

Our AMA:

1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance" policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.
5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.
6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.
7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.

8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development andlocal public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.
CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

School-Based and School-Linked Health Centers, H-60.921
Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.
CSAPH Rep. 1, A-15

Adolescent Health, H-60.981
It is the policy of the AMA to work with other concerned health, education, and community groups in the promotion of adolescent health to: (1) develop policies that would guarantee access to needed family support services, psychosocial services and medical services; (2) promote the creation of community-based adolescent health councils to coordinate local solutions to local problems; (3) promote the creation of health and social service infrastructures in financially disadvantaged communities, if comprehensive continuing health care providers are not available; and (4) encourage members and medical societies to work with school administrators to facilitate the transformation of schools into health enhancing institutions by implementing comprehensive health education, creating within all schools a designated health coordinator and ensuring that schools maintain a healthy and safe environment.
Res. 252, A-90; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed CSAPH Rep. 01, A-17

Providing Medical Services Through School-Based Health Programs, H-60.991
(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should

be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.
CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12

Improving Pediatric Mental Health Screening, H-345.977
Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.
Res. 414, A-11; Appended: BOT Rep. 12, A-14; Reaffirmed: Res. 403, A-18

Access to Mental Health Services, H-345.981
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:
(1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
(2) improving public awareness of effective treatment for mental illness;
(3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
(4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;
(5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and
(6) reducing financial barriers to treatment.
CMS Res. 9, A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11, Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed: Res. 503, A-17; Reaffirmation: I-18

School Resource Officer Qualifications and Training, H-60.902
Our AMA encourages: (1) an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and others deemed necessary for school resource officers; and (2) the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors.
Res. 926, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(A-22)

Introduced by: Illinois

Subject: Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Nonconsensual pornography is a relatively new phenomenon that has grown substantially in the past few years, and involves uploading nude or semi-nude images/videos of a person online without their consent; and

Whereas, 80 to 93 percent of victims suffer significant emotional distress after the release of their explicit photographs; and

Whereas, Victims are not only cyber harassed by their abuser, but also by online users who have viewed their posted photographs; and

Whereas, The impact of nonconsensual pornography includes public shame and humiliation, an inability to find new romantic partners, mental health effects such as depression and anxiety, job loss or problems securing new employment, and offline harassment and stalking; and

Whereas, Cyberbullying violence is associated with a range of mental health issues, including behavioral and emotional problems, reduced self-esteem and substance use; and

Whereas, Victims may suffer termination of employment or may have difficulty gaining future employment and some victims resort to changing their names in an attempt to escape their past; and

Whereas, Once a photo is posted online, it is challenging to completely remove from the Internet, which means the harm is continuous and long lasting; and

Whereas, Many victims experience severe mental health effects and are diagnosed with post-traumatic stress disorder, anxiety, and depression; and

Whereas, Post-traumatic stress disorder is associated with an increased risk of disease, including chronic musculoskeletal pain, hypertension, and cardiovascular disease; and

Whereas, Exposure to stimuli that is triggering to the traumatic memory in post-traumatic stress disorder leads to increased sensitization, and increases the severity of individual psychosomatic sequelae over time; therefore be it

RESOLVED, That our American Medical Association amend policy H-515.967, "Protection of the Privacy of Sexual Assault Victims," by addition to read as follows:

> Protection of the Privacy of Sexual Assault Victims H-515.967
> The AMA opposes the publication or broadcast of sexual assault victims' names, addresses, images or likenesses without the explicit permission of the victim. The AMA additionally opposes the publication (including posting) or broadcast of videos, images, or recordings of any illicit activity of the assault. The AMA opposes the use of such video, images, or recordings for financial gain and/or any form of benefit by any entity. (Modify Current HOD Policy)

RESOLVED, That our AMA research issues related to the distribution of intimate videos and images without consent to find ways to protect these victims to prevent further harm to their mental health and overall well-being. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

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RELEVANT AMA POLICY:

Protection of the Privacy of Sexual Assault Victims H-515.967
The AMA opposes the publication or broadcast of sexual assault victims' names, addresses, or likenesses without the explicit permission of the victim.
Citation: Res. 406, A-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: CEJA Rep. 03, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(A-22)

Introduced by: Medical Student Section

Subject: Improving the Health and Safety of Sex Workers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Sex work entails the provision of sexual services for money or goods, while sex trafficking is defined as the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act[1-3]; and

Whereas, Survival sex is the exchange of sexual activity for basic necessities such as shelter, food, or money; survival sex is considered a subset of “sex work” since it does not involve the force, fraud, or explicit coercion defined in sex trafficking[4]; and

Whereas, Consent is defined by the federal government as a freely given agreement to the conduct at issue by a competent person, and consent is not constituted by lack of verbal or physical resistance[5-7]; and

Whereas, Coercive sex--in the setting of economic, substance-related, or social vulnerability—often problematically falls under the term “consensual” sex work; thus, consent in the realm of sex work falls on a spectrum, rather than a binary definition[5-7]; and

Whereas, Globally, the three major policy approaches to sex trade regulation are (1) criminalization, (2) full and partial decriminalization, and (3) legalization, and the US primarily uses criminalization; and

Whereas, Criminalization of the selling of sex is associated with higher prevalence of unsafe practices such as not using condoms, higher rates of sexually transmitted infections (STIs), lower likelihood of seeking healthcare for illness or injury related to sex work, and greater likelihood of violence and rape of the individuals selling sex[8-17]; and

Whereas, Criminalization of the selling of sex is associated with higher rates of sexual harassment, rape, and violence perpetrated by police against people selling sex[17-20]; and

Whereas, In a study on the mental health of legal and illegal sex workers, illegal sex workers were four times more likely to report mental health issues, possibly due to increased risks that come with illegal sex work such as assault and arrest[21]; and

Whereas, Because sex work is criminalized in the United States, many sex workers struggle to obtain health insurance, leading to the majority being uninsured and paying out of pocket for healthcare[22]; and

Whereas, In 2019, nearly 27,000 people, many of whom were parents, were arrested for prostitution and commercial vices in the United States, putting their children at an increased risk for depression, anxiety, antisocial behavior, drug use, and cognitive delays[23,24]; and

Whereas, Many sex workers have criminal records from the criminalization of selling sex, which, in conjunction with a high rate of mental health problems including increased rates of depression, PTSD, suicidality, dissociation, and substance use disorders, poses a significant barrier in attaining the economic stability needed to successfully exit the sex industry and attain and maintain other employment[25-31]; and

Whereas, A study of 854 sex workers' experiences found 89% of them reported wanting to leave sex work, but named lack of safety, job training, and financial and psychological support and other barriers as preventing their leaving, and other smaller studies have had similar findings and shown that leaving the sex industry usually takes multiple attempts of exit-reentry-exit cycles[25,32-34]; and

Whereas, A systematic review of the literature estimates that 15-20% of men in the United States have paid for sex at least once; and surveys show up to 37% of buyers believe that if they pay for sex, the sex worker is obligated to do anything they ask, and 19% admit to having committed rape[35-39]; and

Whereas, Individuals who sell sex for survival are often those from among the most vulnerable communities, such as undocumented immigrants, minoritized racial and ethnic populations, the economically marginalized, homeless or runaway youth, homeless populations in general and especially homeless LGBTQ+ populations, and transgender people[20,40-49]; and

Whereas, In a nationwide study, 12% of trans women reported earning income through sex work, with higher rates among trans women of color, with 77% of these women reported intimate partner violence, 72% reported sexual assault, and 86% reported police harassment[20]; and

Whereas, The World Health Organization, UNFPA, UNAIDS, the Global Network of Sex Work Projects, Amnesty International, and Human Rights Watch all recommend decriminalizing consensual sex work to improve access to health care for high-risk populations, with the WHO specifying that decriminalization would help reduce HIV incidence[17,50,51]; and

Whereas, The Equality Model, in which the selling of sex is decriminalized, while buying sex, acting as a third-party profiteer, and brothel-owning are criminalized, is the most widely followed system of partial decriminalization and is employed in Sweden, Norway, Iceland, France, Ireland, Northern Ireland, Canada, and Israel[52]; and

Whereas, In the Equality Model, people currently selling sex are offered voluntary participation in social services, and people found to be buying sex are offered voluntary participation programs to help them stop buying sex[52]; and

Whereas, Partial decriminalization strategies such as the Equality Model are associated with a markedly lower rate of human trafficking, while full decriminalization and legalization are associated with (1) increases in human trafficking to meet the increased demand for commercial sex, as well as (2) increases in organized crime[52-54]; and

Whereas, Transition from criminalization to the decriminalization of the sale of sex in the Equality Model in Sweden was shown to lower demand and overall rates of prostitution, led to a comparatively lower number of persons trafficked compared to surrounding nations using other policy systems[45,55,56]; and

Whereas, An article in the AMA *Journal of Ethics* suggested the Equality Model, to be the most effective and ethical approach to addressing the issue of sex work and human rights violations[57]; and

Whereas, Among the various systems of prostitution policy, only the Equality Model has resulted in net decreases of human trafficking, violence against sex workers, and STI rates among the general population[45,50-57]; and

Whereas, Although research has documented the effects of current involvement in the sex industry, research on long-term impacts remains scarce[32,58]; therefore be it

RESOLVED, That our American Medical Association recognize the adverse health outcomes of criminalizing consensual sex work (New HOD Policy); and be it further

RESOLVED, That our AMA: 1) support legislation that decriminalizes individuals who offer sex in return for money or goods; 2) oppose legislation that decriminalizes sex buying and brothel keeping; and 3) support the expungement of criminal records of those previously convicted of sex work, including trafficking survivors (New HOD Policy); and be it further

RESOLVED, That our AMA support research on the long-term health, including mental health, impacts of decriminalization of the sex trade. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

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RELEVANT AMA POLICY

Commercial Exploitation and Human Trafficking of Minors H-60.912

Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.
Citation: Res. 009, A-17

Promoting Compassionate Care and Alternatives for Individuals Who Exchange Sex for Money or Goods H-515.958

Our AMA supports efforts to offer opportunities for a safe exit from the exchange of sex for money or goods if individuals choose to do so, and supports access to compassionate care and best practices. Our American Medical Association also supports legislation for programs that provide alternatives and resources for individuals who exchange sex for money or goods, and offer alternatives for those arrested on related charges rather than penalize them through criminal conviction and incarceration.
Citation: Res. 14, A-15; Modified: Res. 003, I-17

HIV/AIDS as a Global Public Health Priority H-20.922

In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:
(1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
(2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
(3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
(4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
(5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
(6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;

(7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;
(8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and
(9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.
Citation: CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08; Reaffirmation I-11; Appended: Res. 516, A-13; Reaffirmation I-13; Reaffirmed: Res. 916, I-16; Modified: Res. 003, I-17

Global HIV/AIDS Prevention H-20.898
Our AMA supports continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives or grantee pledges of opposition to the exchange of sex for money or goods.
Citation: Res. 439; A-08; Modified: Res. 003, I-17

Physicians Response to Victims of Human Trafficking H-65.966
1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.
Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.
The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.
The Polaris Project -
In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:
- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
a. An assessment tool for health care professionals
b. Online training in recognizing and responding to human trafficking in a health care context
c. Speakers and materials for in-person training
d. Links to local resources across the country
The Rescue & Restore Campaign -
The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.
2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.
Citation: (BOT Rep. 20, A-13; Appended: Res. 313, A-15)

Human Trafficking / Slavery Awareness D-170.992
Our AMA will study the awareness and effectiveness of physician education regarding the recognition and reporting of human trafficking and slavery.
Citation: Res. 015, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(A-22)

Introduced by: Medical Student Section

Subject: Evaluating Scientific Journal Articles for Racial and Ethnic Bias

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Race is a self-identified social construct that results in differential treatment of groups
2 that leads to social inequity on people's health[1,2]; and
3
4 Whereas, According to the U.S. Census 2020 Bureau, ethnicity refers to an individual's self-
5 identification of their origin or descent, "roots," heritage, or place where the individual or their
6 parents or ancestors were born[3]; and
7
8 Whereas, Our AMA recognizes that race and ethnicity are conceptually distinct (H-460.924);
9 and
10
11 Whereas, In practice, race and ethnicity are often inappropriately used interchangeably as
12 demonstrated across the United States where the terms "Latino/a/x, Hispanic, Spanish and
13 Chicano/a/x" have been used interchangeably with race in case report[4-7]; and
14
15 Whereas, Racial and ethnic categories are dependent on self-identification and self-reporting of
16 origin and cultural heritage, constructs which can change over time[8,9]; and
17
18 Whereas, Racial and ethnic classification is highly inconsistent in literature, and evidence-based
19 consensus is necessary for optimal use of self-identified race as well as geographical
20 ancestry[10]; and
21
22 Whereas, In 2017, our AMA recognized assumptions attributed to race and ethnicity can
23 contribute to the inequitable treatment of patients as it relates to evidence-based medicine[11];
24 and
25
26 Whereas, A current review examining ten studies and over 1.5 million participants demonstrated
27 an association between ethnic minorities including Black, Hispanic, South Asian, Southeast
28 Asian, and Chinese, and greater wait time for medical care for chest pain in the emergency
29 department[12]; and
30
31 Whereas, In a study of 4.2 million Medicare beneficiaries who utilized home health services in
32 2015, there was substantial variation between states in administrative data misclassification of
33 self-identified Hispanic, Asian American/Pacific Islander, and American Indian/Alaska Native
34 beneficiaries[13]; and
35
36 Whereas, In a systematic analysis of race/ethnicity and GERD, it was found that only 25 of the
37 62 studies provided complete descriptions of their study populations[14]; and
38
39 Whereas, Conclusions drawn from past interpretations of race and ethnicity have been found to
40 be inconsistent with current understanding of race and ethnicity[15]; and

Whereas, The use of race as a correction factor in the calculation of estimated glomerular filtration (eGFR) has been shown to be unnecessary and less precise than biological measures and has led to irreproducible results[16]; and

Whereas, The race correction factor in eGFR may lead to a delayed referral to a specialist or transplantation and worse outcomes in Black patients[16]; and

Whereas, Race correction factors are still commonplace in cardiology, nephrology, urology, and obstetrics even though many were developed under the belief that race is a useful proxy for biology[16-18]; and

Whereas, Past literature has incorrectly favored a genetic explanation for the difference in birth outcomes between African American and White women[4]; and

Whereas, Current literature states that environmental factors play a greater role in explaining the greater risk of infant mortality in Black women[19]; and

Whereas, The rates of low birth weight and very low birth weight babies among sub-Saharan African-born Black women is less than that of U.S.-born Black women and approximates those of U.S.-born White women, suggesting no significant genetic basis to race differences[4]; and

Whereas, Our AMA Board of Trustees on June 7th, 2020 recognized racism as an urgent threat to public health and resolved to work towards dismantling racist and discriminatory practices across all of healthcare care, and our House of Delegates has adopted multiple policies recognizing racism as a public health threat (H-65.952) and the harm of racial essentialism in medicine and of using race as biology (D-350.981, H-65.953)[20]; and

Whereas, Our AMA states that “race and ethnicity are valuable research variables when used and interpreted appropriately” and “continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients” (H-460.924); and

Whereas, The tools for the evaluation of research integrity exist to determine the strength of their validity and limits of their bias, however lack similar tools to evaluate racial and ethnic bias[21]; therefore be it

RESOLVED, That our American Medical Association support major journal publishers issuing guidelines for interpreting previous research which define race and ethnicity by outdated means (New HOD Policy); and be it further

RESOLVED, That our AMA support major journal publishers implementing a screening method for future research submission concerning the incorrect use of race and ethnicity. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

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RELEVANT AMA POLICY

Code of Medical Ethics 7.1.5

Biomedical and health research is intended to advance medical knowledge to benefit future patients. To achieve those goals physicians who are involved in such research maintain the highest standards of professionalism and scientific integrity.

Physicians with oversight responsibilities in biomedical or health research have a responsibility to ensure that allegations of scientific misconduct are addressed promptly and fairly. They should ensure that procedures to resolve such allegations:

(a) Do not damage science.
(b) Resolve charges expeditiously.
(c) Treat all parties fairly and justly. Review procedures should be sensitive to parties' reputations and vulnerabilities.
(d) Maintain the integrity of the process. Real or perceived conflicts of interest must be avoided.
(e) Maintain accurate and thorough documentation throughout the process.
(f) Maintain the highest degree of confidentiality.
(g) Take appropriate action to discharge responsibilities to all individuals involved, as well as to the public, research sponsors, the scientific literature, and the scientific community.

Issued: 2016

Code of Medical Ethics Opinion 8.5

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate

variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.
This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.
To fulfill this professional obligation in their individual practices physicians should:
(a) Provide care that meets patient needs and respects patient preferences.
(b) Avoid stereotyping patients.
(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
(e) Encourage shared decision making.
(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.
The medical profession has an ethical responsibility to:
(g) Help increase awareness of health care disparities.
(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.
Issued: 2016

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields

related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.
Citation: BOT Action in response to referred for decision Res. 602, I-15

Improving the Health of Black and Minority Populations H-350.972
Our AMA supports:
(1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
(2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
(3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
(4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.
Citation: CLRPD Rep. 3, I-98; Reaffirmation A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 1, A-21

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
Citation: BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

Strategies for Eliminating Minority Health Care Disparities D-350.996
Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.
Citation: (Res. 731, I-02; Modified: CCB/CLRPD Rep. 4, A-12)

Racism as a Public Health Threat H-65.952
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.

2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Citation: Res. 5, I-20

Racial Essentialism in Medicine D-350.981
1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.
2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.
Citation: Res. 10, I-20

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953
1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category “race” can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.
Citation: Res. 11, I-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(A-22)

Introduced by: Medical Student Section

Subject: Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, The World Health Organization has unequivocally defined infertility as a disease state
2 and a cause of disability[1]; and
3
4 Whereas, Gender-affirming hormone therapy (GAHT) includes testosterone therapy for
5 transgender men, which can suppress ovulation, and estrogen therapy for transgender women,
6 which can lead to impaired spermatogenesis and testicular atrophy[2,3]; and
7
8 Whereas, Gender-affirming surgery (GAS) can include hysterectomy and oophorectomy, which
9 results in permanent sterility[2,3]; and
10
11 Whereas, The 2015 U.S. Transgender Survey of almost 28,000 people revealed that 49% of
12 respondents had received GAHT and 25% had undergone some form of GAS[4]; and
13
14 Whereas, The World Professional Association for Transgender Health (WPATH), the Endocrine
15 Society, and the American Society for Reproductive Medicine (ASRM) all recommend that
16 transgender individuals receive counseling regarding potential loss of fertility and future
17 reproductive options before initiating GAHT or undergoing GAS[5–7]; and
18
19 Whereas, As outlined in a recent AMA/GLMA issue brief, Section 1557 of the Affordable Care
20 Act created protections barring insurance discrimination based on sexual orientation and gender
21 identity, although the current Administration has declined to defend this regulation and has been
22 deferential to states[8–10]; and
23
24 Whereas, Employers and states that have implemented coverage of transition-related services
25 have demonstrated minimal or no costs with vast immaterial/societal benefits[10,11]; and
26
27 Whereas, Despite clear expert recommendations, anti-discrimination laws, and evidence of
28 economic benefit, it is still difficult for transgender patients to obtain insurance coverage for
29 gender-affirming care, fertility counseling, and gamete preservation[3,4,12]; and
30
31 Whereas, As of 2020, 17 states have infertility coverage mandates for private insurers, with
32 specific requirements determined on a state-by-state basis[12,13]; and
33
34 Whereas, Seven states (Rhode Island, Connecticut, Delaware, Illinois, New Hampshire, New
35 York, and Maryland) specify mandated coverage for iatrogenic infertility, but language around
36 qualifying diagnoses is variable between states[12,13]; and

Whereas, "Iatrogenic infertility" has been defined in state legislation as impairment of fertility caused by surgery, radiation, chemotherapy, or other medically necessary treatment affecting reproductive organs or processes[12]; and

Whereas, GLMA policy and WPATH Standards of Care support that GAHT and GAS are medically necessary treatments for gender dysphoria, and our AMA supports coverage of medically necessary treatments for gender dysphoria as recommended by the patient's physician (H-185.950)[7,14]; and

Whereas, Our AMA supports the right to seek fertility preservation services for members of the transgender and non-binary community seeking gender-affirming hormone therapy or surgery, but does not currently address insurance coverage for these services (H-65.956); and

Whereas, Our AMA will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility is "caused directly or indirectly by necessary medical treatments as determined by a licensed physician" (H-185.990); and

Whereas, As legislation around coverage of fertility preservation continues to evolve, it is imperative that equitable insurance coverage for transgender patients is ensured; therefore be it

RESOLVED, That our American Medical Association amend policy H-185.990, "Infertility and Fertility Preservation Insurance Coverage." by addition to read as follows:

> Infertility and Fertility Preservation Insurance Coverage H-185.990
>
> It is the policy of the AMA that (1) Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; (2) Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician<u>; and (3) Our AMA encourages the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility</u>. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-185.950, "Removing Financial Barriers to Care for Transgender Patients," by addition to read as follows:

> Removing Financial Barriers to Care for Transgender Patients H-185.950
>
> Our AMA supports public and private health insurance coverage for <u>medically necessary</u> treatment of gender dysphoria as recommended by the patient's physician<u>, including gender-affirming hormone therapy and gender-affirming surgery</u>. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

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RELEVANT AMA POLICY

Right for Gamete Preservation Therapies H-65.956

1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies.

Citation: Res. 005, A-19

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

Citation: (Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14)

Removing Financial Barriers to Care for Transgender Patients H-185.950

Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

Citation: Res. 122; A-08; Modified: Res. 05, A-16

Sexual Orientation and/or Gender Identity as Health Insurance Criteria H-180.980

The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity.
Citation: Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97; Reaffirmed: CMS Rep. 9, A-07; Modified: BOT Rep. 11, A-07; Reaffirmed: CMS Rep. 01, A-17

Infertility Benefits for Veterans H-510.984
1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.
5. Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.
Citation: CMS Rep. 01, I-16; Appended: Res. 513, A-19;

Storage & Use of Human Embryos- Ethics 4.2.5
Embryos created during cycles of in vitro fertilization (IVF) that are not intended for immediate transfer are often frozen for future use. The primary goal is to minimize risk and burden by minimizing the number of cycles of ovarian stimulation and egg retrieval that an IVF patient undergoes. While embryos are usually frozen with the expectation that they will be used for reproductive purposes by the prospective parent(s) for whom they were created, frozen embryos may also offer hope to other prospective parent(s) who would otherwise not be able to have a child. Frozen embryos also offer the prospect of advancing scientific knowledge when made available for research purposes. In all of these possible scenarios, ethical concerns arise regarding who has authority to make decisions about stored embryos and what kinds of choices they may ethically make. Decision-making authority with respect to stored embryos varies depending on the relationships between the prospective rearing parent(s) and any individual(s) who may provide gametes. At stake are individuals' interests in procreating. When gametes are provided by the prospective rearing parent(s) or a known donor, physicians who provide clinical services that include creation and storage of embryos have an ethical responsibility to proactively discuss with the parties whether, when, and under what circumstances stored embryos may be:
(a) Used by a surviving party for purposes of reproduction in the event of the death of a partner or gamete donor.
(b) Made available to other patients for purposes of reproduction.
(c) Made available to investigators for research purposes, in keeping with ethics guidance and on the understanding that embryo(s) used for research will not subsequently be used for reproduction.
(d) Allowed to thaw and deteriorate.
(e) Otherwise disposed of.
Under no circumstances should physicians participate in the sale of stored embryos
Issued: 2016

Assisted Reproductive Technology- Ethics 4.2.1
Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover assisted reproductive services may also be financially vulnerable. Candor and respect are thus essential for ethical practice. “Assisted reproductive technology” is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants. Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer assisted reproductive services should:
(a) Value the well-being of the patient and potential offspring as paramount.
(b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
(c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.
(d) Provide patients with psychological assessment, support and counseling or a referral to such services.
(e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
(f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
(g) Participate in the development of peer-established guidelines and self-regulation.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013
(A-22)

Introduced by: Resident and Fellow Section

Subject: Recognition of National Anti-Lynching Legislation as Public Health Initiative

Referred to: Reference Committee Amendments to Constitution and Bylaws

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1 Whereas, Lynching is defined "as to put to death by mob action without legal approval or
2 permission"[1,2]; and
3
4 Whereas, In the 20th century lynching occurred mostly in southern states by White southerners
5 against Black southerners, however, it was not limited to this region alone nor to Black
6 Americans. Other minority populations were vulnerable to experiencing lynching such as
7 Latinos, Native Americans and Asian Americans[3,4]; and
8
9 Whereas, Historical trauma is defined by the U.S. Department of Health and Human Services as
10 "multigenerational trauma experienced by a specific cultural, racial or ethnic group"[3,4]; and
11
12 Whereas, Health outcomes and impact related to historical trauma can be defined by the U.S.
13 Department of Health and Human Services as depression, fixation on trauma, low self-esteem,
14 anger and self-destructive behavior and can be experienced by descendants who have not
15 directly experienced a traumatic event[4-7]; and
16
17 Whereas, Today's vulnerable populations experience historical trauma that can be contributed
18 to lynching practices under the Jim Crow period (1870-1965)[7]; and
19
20 Whereas, In 1947, the journal of the National Medical Association called for lynching to be
21 named a federal offense as "…there is only one remedy and that is for Congress to enact a law
22 making lynching a federal crime to be tried not by a local jury but in a United States court…"[8];
23 and
24
25 Whereas, Current bill H.R.55 introduced in the 117th Congress known as the "Emmett Till
26 Antilynching Act" has been introduced into Congress for more than 120 years and has not
27 passed due to Congressional mishandlings[9,10]; and
28
29 Whereas, H.R. 55 and previous iterations of this Act are focused on amending section 249 of
30 Title 18, United States Code, to specify lynching as a hate crime act[9,10]; and
31
32 Whereas, Current AMA policy H-65.965, "Support of Human Rights and Freedom" states, "Our
33 AMA recognizes that hate crimes pose a significant threat to the public health and social welfare
34 of the citizens of the United States, urges expedient passage of appropriate hate crimes
35 prevention legislation in accordance with our AMA's policy through letters to members of
36 Congress; and registers support for hate crimes prevention legislation, via letter, to the
37 President of the United States"; therefore be it

RESOLVED, That our American Medical Association support national legislation that recognizes lynching and mob violence towards an individual or group of individuals as a hate crimes (New HOD Policy); and be it further

RESOLVED, That our AMA work with relevant stakeholders to support medical students, trainees and physicians receiving education on the inter-generational health outcomes related to lynching and its impact on the health of vulnerable populations (Directive to Take Action); and be it further

RESOLVED, That AMA policy H-65.965, Support of Human Rights and Freedom, be amended by addition to read as follows:

> Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with his or ger individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, <u>phenotypic appearance,</u> religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA reaffirm policy H-65.952 "Racism as a Public Health Threat". (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

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RELEVANT AMA POLICY

Adverse Childhood Experiences and Trauma-Informed Care H-515.952
1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
2. Our AMA supports:
a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life; and
f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.
3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.
Citation: Res. 504, A-19; Appended: CSAPH Rep. 3, A-21;

Racism as a Public Health Threat H-65.952
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Citation: Res. 5, I-20;

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation,

gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

Reference Committee A

CMS Report(s)

03 Preventing Coverage Losses After the Public Health Emergency Ends
04 Parameters of Medicare Drug Price Negotiation

Resolution(s)

101 Fertility Preservation Benefits for Active-Duty Military Personnel
102 Bundling Physician Fees with Hospital Fees
103 COBRA for College Students
104 Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for Health Care Financing
105 Health Insurance that Fairly Compensates Physicians
106 Hospice Recertification for Non-Cancer Diagnosis
107 Medicaid Tax Benefits
108 Payment for Regadenoson (Lexiscan)
109 Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits
110 Private Payor Payment Integrity
111 Bundled Payments and Medically Necessary Care
112 Support for Easy Enrollment Federal Legislation
113 Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation
114 Oral Healthcare IS Healthcare
115 Support for Universal Internet Access
116 Reimbursement of School-Based Health Centers
117 Expanding Medicaid Transportation to Include Healthy Grocery Destinations
118 Caps on Insulin Co-Payments for Patients with Insurance
119 Medicare Coverage of Dental, Vision and Hearing Services
120 Expanding Coverage for and Access to Pulmonary Rehabilitation
121 Increase Funding, Research and Education for Post-Intensive Care Syndrome
122 Medicaid Expansion
123 Advocating for All Payer Coverage of Cosmetic Treatment for Survivors of Domestic Abuse and Intimate Partner Violence
124 To Require Insurance Companies Make the "Coverage Year" and the "Deductible Year" Simultaneous for Their Policies
125 Education, Forewarning and Disclosure Regarding Consequences of Changing Medicare Plans

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (A-22)
Preventing Coverage Losses After the Public Health Emergency Ends
(Reference Committee A)

EXECUTIVE SUMMARY

During the COVID-19 public health emergency (PHE), states have been required to provide continuous coverage to Medicaid/Children's Health Insurance Program (CHIP) enrollees as a condition for receiving a temporary increase in federal matching funds. Partially as a result, Medicaid/CHIP enrollment has increased by more than 14 million individuals, or 20 percent. Once the PHE ends, states must begin redetermining eligibility for all Medicaid/CHIP enrollees, a massive undertaking that will be operationally challenging for states and may put some Medicaid/CHIP enrollees at risk of losing coverage and becoming uninsured. Because the mass redeterminations will significantly impact people of color, who make up more than half of Medicaid enrollees, it will be critical for policymakers to address health equity implications of the unwinding and how to prevent exacerbation of existing health care inequities. The Council on Medical Service initiated this report to develop American Medical Association (AMA) policy that will help ensure that, as the PHE unwinds, individuals who remain eligible for Medicaid/CHIP retain their coverage and those no longer eligible successfully transition to alternate coverage for which they are eligible, such as subsidized coverage through the Affordable Care Act (ACA) marketplace or employer-sponsored insurance.

At the time this report was written, the PHE remained in effect and states were at various stages of planning for the unwinding. The Council recognizes that the potential for coverage losses and the ability to transition individuals disenrolled from Medicaid/CHIP to other coverage will be highly dependent on how each state performs during the post-PHE period. This report describes the following strategies that are key to state efforts to prevent coverage losses:

- Streamlining enrollment/redetermination/renewal process;
- Investing in outreach and enrollment assistance;
- Adopting continuous eligibility;
- Encouraging auto-enrollment;
- Facilitating coverage transitions, including automatic transitions, to alternate coverage; and
- Monitoring and oversight.

Consistent with these strategies, the Council recommends new AMA policy encouraging states to facilitate transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate coverage for which the individual is eligible, and that auto-transitions meet certain standards. Additionally, the Council recommends supporting coordination between state agencies overseeing Medicaid, ACA marketplaces, and workforce agencies that will help facilitate coverage transitions, and monitoring certain enrollment indicators as the PHE unwinds. Finally, the Council recommends reaffirmation of AMA policies calling for streamlined Medicaid/CHIP enrollment processes and outreach activities (Policy H-290.982); adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans (Policy H-165.855); and auto-enrollment in health insurance coverage (Policy H-165.823).

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-22

Subject: Preventing Coverage Losses After the Public Health Emergency Ends

Presented by: Asa C. Lockhart, MD, MBA, Chair

Referred to: Reference Committee A

During the COVID-19 public health emergency (PHE), states have been required to provide continuous coverage to nearly all Medicaid/Children's Health Insurance Program (CHIP) enrollees as a condition of receiving a temporary increase in federal matching funds. With disenrollments effectively frozen, churn in and out of the program has temporarily ceased and enrollees have experienced two years of coverage stability. Once the PHE and continuous enrollment requirement expire, states will begin redetermining eligibility for all Medicaid /CHIP enrollees and, ideally, retaining eligible enrollees and transitioning those no longer eligible to other affordable coverage, such as through Affordable Care Act (ACA) marketplaces. The mass of impending eligibility redeterminations will be operationally challenging for states and may put significant numbers of Medicaid/CHIP enrollees at risk of losing coverage and becoming uninsured. The Council on Medical Service initiated this report to develop American Medical Association (AMA) policy supportive of strategies that will help ensure continuity of coverage after the PHE ends. This report describes strategies to prevent coverage losses as the PHE unwinds, summarizes relevant AMA policy, and makes policy recommendations.

BACKGROUND

Although Medicaid enrollment had been declining between 2017 and 2019, the arrival of COVID-19 in early 2020 led to rapid and steady enrollment increases that have continued throughout the PHE. Between February 2020 and September 2021 (the latest month for which enrollment data are available), enrollment in Medicaid/CHIP increased by 14.1 million individuals. Most of this growth was in Medicaid, which increased by nearly 13.8 million individuals or 21.6 percent. Total Medicaid/CHIP enrollment in September 2021 topped 84 million, with Medicaid enrolling more than 77 million people.[1]

Experts agree that the growth in Medicaid enrollment has been driven by two factors. First, pandemic-related job losses, especially during the pandemic's first year, made many people newly eligible for Medicaid based on income. Second, provisions in the Families First Coronavirus Response Act (FFCRA) provided a temporary 6.2 percentage point increase in federal Medicaid matching funds to states that meet certain maintenance of eligibility (MOE) requirements, including maintaining continuous coverage of most enrollees throughout the PHE. Because states have not been able to disenroll anyone enrolled in Medicaid on or after March 18, 2020, enrollment has been increasing month over month for well over two years.

At the time this report was written, the PHE had been extended through mid-July 2022. Although it is impossible to know exactly what will happen to Medicaid enrollment after the PHE expires, the number of people covered by Medicaid could decrease substantially. Prior to the pandemic, it was not uncommon for people to lose Medicaid coverage for procedural reasons (e.g., because they did

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not respond to requests for information needed by the Medicaid agency to complete eligibility renewals or because they missed a paperwork submission deadline).[2] According to *Kaiser Health News*, Colorado officials anticipate that, of the 500,000 people whose eligibility will need to be reviewed post-PHE, 40 percent may lose Medicaid due to income while 30 percent will be at risk of losing coverage because of outstanding requests for information.[3]

Workforce challenges across many state Medicaid agencies, and fiscal pressures that may drive some states to complete their redeterminations in an abbreviated timeframe, add to concerns that, post-PHE, Medicaid/CHIP coverage and continuity of care could be disrupted for potentially millions of Americans. Urban Institute has projected that Medicaid enrollment could decline by 13 to 16 million people, depending on the PHE's end date.[4] Additionally, a report from the Georgetown University Health Policy Institute estimated that more than 6 million of the 39.6 million children enrolled in Medicaid/CHIP could lose coverage.[5] Urban Institute projects that one-third of adults losing Medicaid coverage post-PHE could be eligible for premium tax credits for marketplace plans (the American Rescue Plan Act's [ARPA's] enhanced tax credits and elimination of the "subsidy cliff" are currently scheduled to expire after 2022), and an additional 65 percent could have an offer of employer-sponsored coverage in their family. Additionally, Urban Institute estimates that more than half (57 percent) of children losing Medicaid coverage could qualify for CHIP coverage, while an additional 9 percent would be eligible for subsidized marketplace coverage.[6] According to these estimates, most people leaving Medicaid should be eligible for alternate coverage through the marketplace, CHIP, or an employer-sponsored plan. However, without proper notice and assistance, not all will enroll in alternate coverage.

Throughout the pandemic, the Centers for Medicare & Medicaid Services (CMS) has provided periodic guidance to states to support their planning for the eventual end of the PHE in a manner that mitigates coverage disruptions and bolsters consumer protections. CMS guidance[7] includes the following directives:

- States must initiate all Medicaid/CHIP renewals and outstanding eligibility and enrollment actions within 12 months after the month in which the PHE ends and will have two additional months (14 months total) to complete all actions.
- States can begin their unwinding periods up to two months prior to the end of the month in which the PHE ends but cannot terminate enrollees' Medicaid/CHIP coverage before the first day of the month following the end of the PHE. States that begin disenrolling before then can no longer claim the temporary Federal Medical Assistance Percentages (FMAP) increase.
- States must develop an "unwinding operational plan" and determine how they will prioritize and carry out their eligibility redeterminations.
- States should initiate no more than 1/9 of their total Medicaid/CHIP renewals in a given month during the unwinding period.
- States are required to take steps to transition enrollees who are determined ineligible for Medicaid to other insurance affordability programs, such as through ACA marketplaces. As such, states must promptly assess an individual's potential eligibility for marketplace coverage and transfer that individual's electronic account to the marketplace.
- To minimize coverage disruptions among Medicaid enrollees who became eligible for, but did not enroll in, Medicare coverage during the PHE, states are encouraged to reach out and encourage these people to enroll in Medicare.[8]

Policy changes relevant to the end of the PHE were also included in the US House of Representatives-passed Build Back Better Act, although the Senate had not acted by the time this report was written and it is unclear whether any of the House-passed provisions will be considered

in a separate bill. In addition to closing the Medicaid coverage gap—by allowing people with incomes below 138 percent of the federal poverty level to obtain zero-premium marketplace coverage through 2025—the House-passed provisions would extend premium tax credit generosity, cost-sharing assistance and elimination of the subsidy cliff provided under ARPA to the end of 2025 and require 12 months of continuous eligibility for children under Medicaid/CHIP.

HEALTH EQUITY CONCERNS

Before the pandemic, available state Medicaid data showed that more than 60 percent of enrollees identified as Black, Latino/a, or other individuals of color, with studies finding that children of color experienced coverage disruptions at higher rates[9] and enrollees of color experienced poorer outcomes and more barriers to care than whites.[10] It will be critical for state and federal policymakers to address the health equity implications of the PHE unwinding and how to prevent exacerbation of existing health care inequities.

As noted in Council on Medical Service Report 5-Nov-20, Medicaid Reform, the pandemic disproportionately impacted Black, Latino/a and Native American communities and highlighted longstanding health inequities that disproportionately affect minoritized communities. Social drivers including racism contribute to higher rates of chronic diseases, lower access to health care, and lack of or inadequate health insurance, which help propel disparate health outcomes. Black and Latino/a people also experienced the pandemic's economic impacts that contributed to higher unemployment and housing instability, especially among groups that struggle against economic marginalization.[11] Frequent changes in employment may put people at risk of losing Medicaid coverage as the PHE unwinds because income volatility can lead to procedural hurdles and multiple requests for income verification and notices from the state Medicaid agency. People who experience housing instability may also be at risk of being disenrolled by Medicaid if the state is not able to reach them because of outdated contact information.[12] Importantly, disenrollment may also have a particularly damaging impact on people with disabilities, for whom Medicaid can at times be the difference between living independently and in a facility.

STRATEGIES FOR PREVENTING COVERAGE LOSSES AFTER THE PHE ENDS

Because Medicaid is a joint federal-state program, eligibility and enrollment rules, and the processes for implementing these rules, can vary significantly by state. Accordingly, the potential for coverage losses and the ability to transition those disenrolled from Medicaid to other affordable coverage will be highly dependent on how each state performs during the post-PHE period. The following strategies may help ensure that, after the PHE ends, people still eligible for Medicaid/CHIP are appropriately retained while those found ineligible are seamlessly transitioned to subsidized ACA marketplace plans or other affordable coverage for which they are eligible.

Streamline Enrollment/Redetermination/Renewal Processes

Since Medicaid enrollees can lose coverage because they did not receive a renewal form or return information on time, it is important that states improve redetermination processes by maximizing the use of automatic renewals based on available data sources such as Internal Revenue Service and quarterly wage data, unemployment claims, or information from the Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families (TANF). The use of data sources to verify continued eligibility is known as *ex parte* renewal and it minimizes churn because it reduces administrative errors and does not require action by the enrollee. Medicaid rules generally require states to attempt to confirm eligibility *ex parte* before sending out renewal documents and requiring enrollees to respond.[13] However, if an *ex parte* renewal cannot be completed, state

Medicaid agencies must contact enrollees directly to request information needed to verify eligibility. Completing renewals by traditional means (e.g., forms transmitted through the mail) can be problematic when enrollees are not aware of the steps they need to take to retain coverage or if they have moved or have outdated contact information on file with the state.

Notably, state implementation of Medicaid rules intended to streamline renewal processes vary significantly across states, as does the percentage of completed *ex parte* renewals, with some states completing under a quarter of renewals *ex parte* and others renewing 75-90 percent using existing data sources.[14] While states will always have enrollees with complex situations or who otherwise must be renewed using traditional formats—either online, in-person or by phone—states should be encouraged to streamline renewals and improve *ex parte* renewal rates.

Invest in Outreach and Enrollment Assistance

Effective communications between states and Medicaid/CHIP enrollees, physicians and other providers, health plans, and community organizations will be important to ensuring that everyone is aware of and engaged in state preparations for the mass eligibility redeterminations. CMS has encouraged states to conduct outreach to remind enrollees to update contact information on file with the state Medicaid agency.[15] Without such information, enrollees who have moved during the pandemic may not receive renewal notices and could be disenrolled from Medicaid while still actually eligible. States that effectively communicate with Medicaid enrollees may prevent coverage losses by making people aware of upcoming redeterminations and actions they must take to retain coverage.

It will also be important for states to target specific outreach to people with disabilities or limited English proficiency and enrollees experiencing homelessness. Many states have planned outreach campaigns to encourage people to make sure their contact information in the state health care database is accurate and up to date. CMS has encouraged states to partner with health plans to update contact information and communicate with Medicaid enrollees, using multiple modalities—mail, email, and text— to reach people. Equally as important, states will need to communicate with enrollees no longer deemed eligible for Medicaid that they may be eligible for no- or low-cost marketplace plans and inform them how to enroll. Navigators embedded across community-based organizations and health plans may be utilized to help conduct outreach and empower people to enroll in marketplace plans.

Adopt Continuous Eligibility

Continuous eligibility policies, which allow enrollees in Medicaid, CHIP and marketplace plans to maintain coverage for 12 months, have long been supported by the AMA as a strategy to reduce churn that occurs when people lose coverage and then re-enroll within a short period of time. Churn-induced coverage disruptions are most pronounced in Medicaid, both because income fluctuations are common and because Medicaid enrollees can lose coverage for procedural reasons.[16]

Once the PHE and FFCRA continuous enrollment requirements expire, continuous eligibility will remain an option for states through Section 1115 waivers. While more states may be looking into this option, at the time this report was written only New York and Montana had continuous eligibility policies in place for adult enrollees. States have had the option to adopt continuous eligibility for children with Medicaid and CHIP coverage since 1997 and many—but not all—states have done so. At the time this report was written, 27 states had implemented continuous eligibility for children enrolled in CHIP while 25 states had it for children enrolled in Medicaid.[17]

Providing continuous eligibility to individuals who remain eligible after post-PHE redeterminations would ensure continuity of Medicaid/CHIP coverage for large numbers of people. Importantly, without continuous enrollment policies in place, states will return to normal procedures that base Medicaid eligibility on a family's current monthly income. Typically, states check data sources and require enrollees to report even small income fluctuations that may put them just above the Medicaid income threshold in some months. An important example of continuous eligibility for a subsection of Medicaid enrollees is the option for states—made available under ARPA—to extend postpartum coverage to 12 months. Consistent with AMA policy, this option is intended to improve maternal health and coverage stability and to help address racial disparities in maternal health.[18]

Encourage Auto-Enrollment

Auto-enrollment in marketplace coverage, Medicaid/CHIP, and employer-sponsored coverage was addressed by the Council in Council on Medical Service Report 1-Nov-20 as a means of expanding coverage. Maryland's Easy Enrollment Health Insurance Program is an auto-enrollment initiative that facilitates health coverage through tax filing by allowing filers to share insurance status and income on tax forms and authorize the state to determine whether they are eligible for Medicaid or subsidized marketplace plans.[19] During the first year of implementation in 2020, over 60,000 Marylanders shared their information via Easy Enrollment. Most were found eligible for Medicaid or marketplace coverage and over 4,000 people were auto-enrolled in coverage.[20] Other states considering similar "easy enrollment" programs include Colorado and New Jersey.[21]

State departments of motor vehicles and unemployment insurance systems have also been identified as potential avenues for leveraging auto-enrollment in health coverage. Legislation adopted in Maryland and under consideration in New Jersey would allow individuals applying for unemployment to share information and permit the state to offer Medicaid or marketplace coverage to eligible individuals.[22] While several states have expressed interest in various approaches to auto-enrollment, income verification and citizenship attestation have been identified as barriers to implementation.[23]

Facilitate Coverage Transitions, Including Automatic Transitions

As states undertake redeterminations of all Medicaid and CHIP enrollees once the PHE expires, many people disenrolled because their incomes have risen will be eligible for subsidized coverage through state or federally facilitated marketplaces or through a Basic Health Program (BHP) in states that operate a BHP (Minnesota and New York). However, in most states transitioning people to marketplace coverage from Medicaid is not automatic and may be difficult for people to navigate. Additionally, some people disenrolled from Medicaid may not know that they are eligible for subsidized marketplace coverage or may think the plans are unaffordable.[24] Although ARPA increased subsidies for all those eligible, including newly eligible over 400 percent of the federal poverty level, these provisions will expire at the end of 2022 unless Congress extends them. If the ARPA subsidies expire, people enrolled in subsidized marketplace plans this year may be at risk of coverage lapses next year once eligibility and premiums are reset for their marketplace plans.

Before the ACA, Massachusetts implemented its own subsidized health insurance exchange (Commonwealth Care) along with a policy that automatically switched premium lapsers into a free plan, if one was available, rather than disenrolling them. Researchers found that this policy prevented coverage losses among 14 percent of enrollees eligible for zero premium plans and that those retained were younger, healthier, and less costly to insure.[25] Another Massachusetts policy temporarily associated with its pre-ACA exchange auto-enrolled people who were found eligible

for Commonwealth Care—through either an application for the exchange or a Medicaid redetermination—but who did not actively choose a plan. This policy, which applied only to people with incomes below 100 percent of the federal poverty level, was found to significantly increase enrollment.[26]

Some state Medicaid agencies already partner with their state's marketplace to identify strategies for improving transitions from Medicaid to marketplace coverage and identifying barriers to seamless transitions. Information technology (IT) challenges can present barriers to smooth coverage transitions, especially in states that have not updated and/or integrated their IT systems so they are able to share eligibility information between Medicaid/CHIP and the marketplace.[27] Those states that already have integrated IT systems in place may have an easier time auto-transitioning people from Medicaid to the marketplace, or from marketplace plans to Medicaid. However, at the time this report was written, most states had not integrated their Medicaid and marketplace eligibility systems, which could make it more difficult to switch people from one source of coverage to another. The degree to which state Medicaid and marketplace agencies work together matters greatly but varies across states and may be more challenging in states that do not run their own marketplaces.

Provide Monitoring and Oversight

It will be critical that states monitor the effectiveness of their policies and plans as the PHE unwinds so they become aware of concerning indicators signaling a need for the state to intervene or change course. In particular, states should monitor Medicaid/CHIP enrollment and disenrollment data and whether individuals are being disenrolled appropriately due to income or because of procedural or paperwork issues. States experiencing unusually high levels of churn may need to take steps to ensure that enrollees still eligible for Medicaid/CHIP are being appropriately retained. Similarly, increases in the numbers of newly uninsured individuals should suggest to states that new policy or action may be needed to address avoidable churn and/or whether new procedures are needed to facilitate transitions between coverage programs. CMS has indicated that the agency will monitor a state's progress in completing its redeterminations and that states will need to submit baseline and then monthly data during the unwinding period.[28] At a minimum, states should be encouraged to track and make available key enrollment data to ensure appropriate monitoring and oversight of Medicaid/CHIP retention and disenrollment, successful transitions to new coverage, and numbers and rates of uninsured.

EXAMPLES OF STATE PLANS FOR THE UNWINDING OF THE PHE

At the time this report was written, the PHE remained in effect and states were in various stages of planning for the unwinding. In a January 2022 survey conducted by the Kaiser Family Foundation and Georgetown University Center for Children and Families, 27 states indicated that they had developed plans for resuming redeterminations once the continuous coverage requirement is lifted.[29] This survey also found that 39 states intend to take up to a full year to process redeterminations (9 states plan to do so more quickly); 46 states are planning to update enrollee mailing addresses before the PHE expires; and 30 states are taking steps to increase agency staffing in order to process the renewals. Among states that were able to project anticipated disenrollments as the PHE unwinds, estimates varied widely across states and ranged from 8 percent to 30 percent of total enrollees potentially losing Medicaid coverage.[30]

Washington State plans to use most of the time allotted by CMS after the PHE ends to complete its redeterminations. The State of Washington Health Care Authority has been keeping up with renewals throughout the PHE (without disenrolling anyone) and, once it expires, will attempt to

auto-renew enrollees using the state's Healthplanfinder system.[31] Because Healthplanfinder is an integrated system, it can help facilitate transitions of enrollees who are no longer Medicaid-eligible to marketplace plans for which they are eligible. Additionally, the State of Washington has over 900 navigators located at clinics and community support organizations around the state and over 1600 state-certified brokers available to help people stay covered.[32]

By the fall of 2021, California's Department of Health Care Services was already preparing for redeterminations of nine to ten million Medi-Cal recipients by, among other strategies, working with health navigators, advocates, managed care plans and community-based organizations to communicate the need for enrollees to update their contact information.[33] Under state legislation (S.B. 260) passed in 2019, the state's health insurance exchange—Covered California—is required to automatically enroll individuals no longer eligible for Medicaid (Medi-Cal) into the lowest cost silver plan before they are terminated.[34] As the PHE unwinds, California's Healthcare Eligibility, Enrollment, and Retention System (CalHEERS)—an integrated system supporting eligibility, enrollment, and retention for Covered California, Medi-Cal, and Healthy Families—will be used to auto-transition individuals no longer eligible for Medi-Cal into subsidized Covered California plans.[35]

In Ohio, the state legislature included language in its biennial budget bill that set parameters around the state's post-COVID Medicaid redeterminations. As passed by the General Assembly, H.B. 110 requires the Ohio Department of Medicaid to conduct eligibility redeterminations of all Ohio Medicaid recipients within 90 days after the PHE expires. The legislation further requires expedited eligibility reviews of enrollees identified as likely ineligible for Medicaid within 90 days and—to the extent permitted under federal law—disenroll those people who are no longer eligible.[36] Multiple media outlets have reported that $35 million was appropriated by the state to contract with an outside vendor (Boston-based Public Consulting Group) to automate its eligibility redeterminations in exchange for a share of the savings.[37,38]

RELEVANT AMA POLICY

The AMA's long-standing goals to cover the uninsured and improve health insurance affordability are reflected in a plethora of AMA policies and the AMA proposal for reform. Among the most relevant policies are those that support the adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans to limit patient churn and promote the continuity and coordination of patient care (Policies H-165.832 and H-165.855). AMA policy also supports investments in outreach and enrollment assistance activities (Policies H-290.976, H-290.971, H-290.982 and D-290.982). Policy H-290.982 calls for states to streamline enrollment in Medicaid/CHIP by, for example, developing shorter applications, coordinating Medicaid and TANF application processes, and placing eligibility workers where potential enrollees work, go to school, and receive medical care, and urges CMS to ensure that outreach efforts are culturally sensitive. This policy also urges states to undertake, and state medical associations to take part in, educational and outreach activities aimed at Medicaid and CHIP-eligible children. The role of community health workers is addressed under Policy H-440.828, while Policy H-373.994 delineates guidelines for patient navigator programs.

Policy D-290.979 directs the AMA to work with state and specialty medical societies to advocate at the state level in support of Medicaid expansion. Policy D-290.974 supports the extension of Medicaid and CHIP coverage to at least 12 months after the end of pregnancy. Policy H-290.958 supports increases in states' FMAP or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment.

Medicaid and incarcerated individuals addressed by Policy H-430.986. Policy H-290.961 opposes work requirements as a criterion for Medicaid eligibility.

Policy H-165.839 advocates that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information. Policy H-165.823 supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to cost of coverage, individual consent, opportunity to opt out after being auto-enrolled, and targeted outreach and streamlined enrollment. Under this policy, individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would therefore include individuals eligible for Medicaid/CHIP or zero-premium marketplace coverage. Individuals eligible for zero-premium marketplace coverage would be randomly assigned among the zero-premium plans with the highest actuarial values. Policy H-165.823 also outlines standards that any public option to expand health insurance coverage, as well any approach to cover individuals in the coverage gap, must meet. Principles for the establishment and operation of state Basic Health Programs are outlined in Policy H-165.832.

Under Policy H-165.824, the AMA supports adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits and encourages state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections. Policy H-165.824 further supports: (a) eliminating the subsidy "cliff", thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level; (b) increasing the generosity of premium tax credits; (c) expanding eligibility for cost-sharing reductions; and (d) increasing the size of cost-sharing reductions.

Policy H-165.822 (1) encourages new and continued partnerships to address non-medical, yet critical health needs and the underlying social determinants of health; (2) supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs; and (3) encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health. Policy H-180.944 states that "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.

DISCUSSION

Medicaid is the largest health insurance program in the US; the leading payer of medical costs associated with births, mental health services and long-term care; and an indispensable safety net for people exposed to poverty. Throughout the PHE, Medicaid and CHIP have provided health coverage and care to more than 80 million people, including individuals affected by COVID-19 and those who experienced pandemic-related job losses. Because of the Medicaid continuous enrollment requirement and enhanced FMAP provided under the FFCRA, states have largely maintained Medicaid/CHIP coverage stability and prevented increases in uninsured rates that would otherwise be expected during a once-in-a-lifetime PHE. The loss of enhanced federal matching funds once the PHE expires will compound the many pressures already facing states and their Medicaid agencies, including budgetary concerns, the duration of time that has passed since the state has had contact with many enrollees, and an ongoing shortage of human services workers trained to complete eligibility redeterminations.

The Council recognizes that states and state Medicaid programs have been operating under considerable financial and administrative strain during the pandemic and that state Medicaid spending may increase when the enhanced federal match dries up at the end of the quarter in which the PHE expires. Most states have experienced substantial enrollment increases over the last two years and many individuals, whose incomes have risen above Medicaid eligibility thresholds, will appropriately be disenrolled as states right-size their programs. The Council maintains that people should be properly enrolled in quality affordable coverage for which they are eligible. At the same time, the Council is concerned that the impending eligibility redeterminations will trigger excessive churn and coverage losses in some states at a time when many enrollees, and state and local governments, are still struggling with the aftereffects of COVID-19. As the PHE unwinds, physicians and other providers may see more patients who do not realize that they are uninsured because they are no longer covered by Medicaid/CHIP. Because even brief gaps in coverage can be costly in terms of interrupting continuity of care and necessary treatments, the Council hopes that states will employ strategies that help them retain Medicaid/CHIP-eligible enrollees and transition those no longer eligible into other affordable health plans.

The appended policy crosswalk outlines the strategies described in this report along with AMA policy that supports adoption of these strategies. As noted, it is anticipated that most people who lose Medicaid/CHIP coverage as the PHE unwinds will qualify for subsidized coverage through the marketplace or for employer-sponsored insurance. Although the ACA expanded the availability of coverage options, transitioning between Medicaid, marketplace and employer-sponsored coverage remains challenging to navigate. Accordingly, the Council recommends encouraging states to facilitate coverage transitions, including automatic transitions, to alternate coverage for which individuals are eligible. If adopted, this new policy would support more seamless coverage transitions among individuals found ineligible for Medicaid/CHIP into other affordable plans. Notably, the recommended policy would also support other coverage transitions, such as: newly unemployed individuals transitioning into Medicaid or marketplace coverage; young adults aging out of CHIP or family coverage securing other affordable coverage for which they may be eligible; and individuals whose marketplace coverage has lapsed because of premium increases moving into a more affordable marketplace plan or Medicaid, if they are eligible. In all circumstances, the Council emphasizes that individuals should be transitioned into the best affordable plans for which they are eligible.

The Council understands that states vary in terms of their ability to facilitate transitions from one source of coverage to another, and that few states are currently prepared to auto-transition people from Medicaid to marketplace coverage. However, we hope that states continue to pursue more seamless coverage transitions in the future. To that end, the Council believes that coordination among state agencies overseeing Medicaid, marketplace plans, and workforce/unemployment offices is integral to helping individuals maintain continuity of care across coverage programs. Accordingly, the Council recommends supporting coordination among state Medicaid, marketplace and workforce agencies that will help facilitate health coverage transitions. The Council also believes strongly that monitoring and oversight will be critical to preventing unnecessary coverage losses and recommends supporting federal and state monitoring of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and uninsured rates.

Finally, the Council recommends reaffirmation of AMA policies calling for streamlined Medicaid/CHIP enrollment processes and outreach activities (Policy H-290.982) and adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans (Policy H-165.855) to minimize churn and ensure that states are appropriately retaining Medicaid/CHIP enrollees. The

Council also recommends reaffirming AMA policy that encourages states to pursue auto-enrollment in health insurance coverage (Policy H-165.823) as a means of expanding coverage.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) encourage states to facilitate transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate health insurance coverage for which the individual is eligible, and that auto-transitions meet the following standards:
    a. Individuals must provide consent to the applicable state and/or federal entities to share information with the entity authorized to make coverage determinations.
    b. Individuals should only be auto-transitioned in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies.
    c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-transitioned.
    d. Individuals should not be penalized if they are auto-transitioned into coverage for which they are not eligible.
    e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
    f. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and special enrollment periods. (New HOD Policy)

2. That our AMA support coordination between state agencies overseeing Medicaid, Affordable Care Act marketplaces, and workforce agencies that will help facilitate health insurance coverage transitions and maximize coverage. (New HOD Policy)

3. That our AMA support federal and state monitoring of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and uninsured rates. (New HOD Policy)

4. That our AMA reaffirm Policy H-290.982, which calls for states to streamline Medicaid/Children's Health Insurance Program (CHIP) enrollment processes, use simplified enrollment forms, and undertake Medicaid/CHIP educational and outreach efforts. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-165.855, which calls for adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans to limit churn and assure continuity of care. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-165.823, which supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to consent, cost, ability to opt out, and other guardrails. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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Appendix
AMA Policy and
Strategies to Prevent Coverage Losses After the Public Health Emergency Ends

Strategy	AMA Policy
Streamline redetermination/renewal processes	Policy H-290.982 calls for states to streamline enrollment processes within Medicaid/CHIP and use simplified application forms.
Invest in outreach and enrollment assistance	Policy H-290.982 urges states to undertake educational and outreach activities and ensure that Medicaid/CHIP outreach efforts are appropriately sensitive to cultural and language diversities.
Adopt continuous eligibility	Policy H-165.855 states that in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans.
Encourage auto-enrollment	Policy H-165.823 supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to cost of coverage, individual consent, opportunity to opt-out, and targeted outreach and streamlined enrollment.
Facilitate coverage transitions, including automatic transitions to alternate coverage	No relevant AMA policy. New policy recommended (see Recommendations 4 and 5)
Provide monitoring and oversight	No relevant AMA policy. New policy recommended (see Recommendation 6)

REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (A-22)
Parameters of Medicare Drug Price Negotiation
(Alternate Resolution 113-N-21)
(Reference Committee A)

EXECUTIVE SUMMARY

At the November 2021 Special Meeting, the House of Delegates referred the second resolve of Alternate Resolution 113, as well as an amendment proffered during consideration of Alternate Resolution 113. The second resolve of Alternate Resolution 113 asked that our American Medical Association (AMA) reaffirm Policy H-110.980, which outlines principles guiding the use of international price indices and averages in determining the price of and payment for drugs, including those covered in Medicare Parts B and D. In contrast, the amendment to Alternate Resolution 113 opposed reaffirmation of Policy H-110.980, and instead asked our AMA to advocate for Medicare drug price negotiation to reduce prices paid by Medicare for medications in Part B and Part D and physician acquisition costs for medications in Part B.

In addition, the amendment proposed to amend Policy H-110.980[2(a)] by addition and deletion to read as follows:

> 2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
>
> ~~a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;~~
>
> a. Any international drug price index used to determine Medicare Part D drug prices should be based on a reasonable percentage of the drug's volume weighted net average price in at least six large western industrialized nations;

The Council understands that the introduction of original Resolution 113-N-21, as well as amendments made during consideration of Alternate Resolution 113-N-21, stemmed from strong support in the House of Delegates for the AMA to advocate on the issue of prescription drug pricing more actively and strongly. The AMA has been "at the table," advocating AMA policy on drug pricing with Congress via meetings with legislators and their staff as well as letters and other communications. The AMA also has engaged the Administration through comment letters in response to regulatory activity as well as direct interactions and meetings. Finally, the AMA and members of the Federation have similarly advocated at the state level.

The AMA's advocacy priorities have been to preserve patient access to necessary medications, and limit burdens on and protect physician practices. While recent legislative and regulatory proposals incorporating international drug price averages and/or indices in Medicare drug pricing have not met these and other important thresholds outlined in Policy H-110.980, the Council believes that is not a reason to change AMA policy. AMA policy needs to be able to proactively respond to the more likely path forward on this issue—through regulation, targeting Medicare Part B drug payment—and needs to be consistent across not only all of Medicare, but across all health plans. The Council does, however, see promise in testing the impact of offering Medicare beneficiaries additional enhanced alternative health plan choices that offer lower, consistent. and predictable out-of-pocket costs for select prescription drugs.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-22

Subject: Parameters of Medicare Drug Price Negotiation (Alternate Resolution 113-N-21)

Presented by: Asa C. Lockhart, MD, MBA, Chair

Referred to: Reference Committee A

At the November 2021 Special Meeting, the House of Delegates referred the second resolve of Alternate Resolution 113, Supporting Medicare Drug Price Negotiation, as well as an amendment proffered during consideration of Alternate Resolution 113. The second resolve of Alternate Resolution 113 asked that our American Medical Association (AMA) reaffirm Policy H-110.980, Additional Mechanisms to Address High and Escalating Pharmaceutical Prices, which outlines principles guiding the use of international price indices and averages in determining the price of and payment for drugs, including those covered in Medicare Parts B and D. In contrast, the amendment to Alternate Resolution 113 opposed reaffirmation of Policy H-110.980, and instead asked our AMA to advocate for Medicare drug price negotiation to reduce prices paid by Medicare for medications in Part B and Part D and physician acquisition costs for medications in Part B.

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> a. Any international drug price index used to determine Medicare Part D drug prices should be based on a reasonable percentage of the drug's volume weighted net average price in at least six large western industrialized nations;

This report provides background on the impacts of high and escalating prescription drug prices and costs; outlines proposals to leverage an international price index in Medicare Parts B and D; summarizes significant AMA policy and advocacy on prescription drug pricing; and presents policy recommendations.

BACKGROUND

The Council understands that the intent of the amendments proposed to Policy H-110.980 was to take significant and concrete action to lower Medicare Parts D and B drug prices and associated patient cost-sharing. Some recent legislative proposals that incorporate international price indices and averages in Medicare drug price negotiation, addressed by Policy H-110.980, would not only extend negotiated prices to Medicare and Medicare Advantage, but also to private health insurance unless the insurer opts out. The Council agrees wholeheartedly that unsustainably high and

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escalating prescription drug prices and costs constitute a consistent and paramount concern for patients and their physicians, employers, states, and the federal government, underpinning the introduction of legislation, or promulgation of regulations, on both the federal and state levels.

Spending on retail prescription drugs totaled $348.4 billion in 2020, accounting for eight percent of total health spending.[1] Other estimates suggest that spending on prescription drugs as a percent of total health spending is greater when other factors, including the non-retail drug markets and gross profits of other stakeholders involved in drug distribution, payment, and reimbursement are included. Significantly, spending on specialty drugs now constitutes more than one-half of drug spending (53 percent).[2] The most recent National Health Expenditure data showed that retail prescription drug spending was estimated to have increased by three percent in 2020. Drivers behind the lower rate of growth in prescription drug spending include a slower overall utilization of prescription drugs and a higher use of coupons, which resulted in a reduction in out-of-pocket expenditures.[3]

Approximately 6.3 billion prescriptions were dispensed in the United States (US) in 2020, 90 percent of which were dispensed as generics.[4] The retail price differentials between specialty, brand-name and generic drugs are noteworthy. Examining the retail prices of drugs widely used by older Americans in 2020—most of whom are Medicare beneficiaries who would be impacted by the proposed, referred amendments to Policy H-110.980—the average annual retail price of therapy with specialty drugs was $84,442, dropping to $6,604 for brand-name drugs, both dwarfing the annual price of therapy for generics.[5]

In Medicare, patients face different cost-sharing for prescription drugs, depending on whether the drugs are covered under Medicare Part B or D. In general, Medicare Part B covers prescription drugs that typically are not self-administered; Part B drugs can be provided in a physician's office as part of their service. In addition, Part B covers limited outpatient prescription drugs, including certain oral cancer drugs. Most other retail prescription drugs for medically accepted indications that are not covered by other parts of Medicare fall under Medicare Part D. Within Medicare Part D, the typical formulary design consists of five tiers: preferred generics, generics, preferred brands, non-preferred drugs, and specialty drugs. Within these tiers, among all stand-alone Medicare Part D prescription drug plans, median standard cost sharing in 2022 is $0 for preferred generics, $5 for generics, $42 for preferred brands, 40 percent coinsurance for non-preferred drugs, and 25 percent coinsurance for specialty drugs.[6] For prescription drugs covered under Medicare Part B, for traditional Medicare beneficiaries without a supplemental plan, cost-sharing for covered Part B drugs equates to 20 percent of the Medicare-approved amount after paying any applicable Part B deductible, with no out-of-pocket limit.[7]

Overall, in the Medicare program, between 2007 and 2019, Part D program spending grew by an average annual rate of 5.5 percent and amounted to $88.4 billion in 2019. Premiums paid by Part D enrollees for basic benefits (not including low-income subsidy enrollees) amounted to $13.9 billion in 2019, a decrease of 2.1 percent from 2018, before which premiums paid by enrollees had been growing by an average of 12 percent per year.[8] Under Medicare Part B, total drug spending amounted to $37 billion in 2019, with the top 50 drugs ranked by total spending accounting for 80 percent of total Medicare Part B drug spending.[9]

Relevant to legislative proposals that extend drug prices achieved by Medicare drug price negotiation to private health insurance, employer-sponsored health plans as well as health plans sold in the individual market have also had to absorb the higher costs of prescription drugs. Higher costs of prescription drugs often translate to higher premiums, higher prescription drug cost-sharing, and additional prescription drug tiers to accommodate the higher costs of specialty and

certain generic drugs. In 2021, 88 percent of employees were enrolled in plans with three, four or more cost-sharing tiers for prescription drugs.[10]

Overall, patient out-of-pocket costs for retail prescription drugs reached $61 billion in 2020, with non-retail out-of-pocket costs amounting to $16 billion. Across Medicare, Medicaid and commercial health plans, eight percent of patients pay more than $500 per year out-of-pocket for prescriptions. Medicare beneficiaries have a notably higher incidence rate of high out-of-pocket expenses for prescription drugs, with 17 percent paying more than $500 out-of-pocket.[11]

The higher costs of prescription drugs impact patient health outcomes and physician practices. Ultimately, prescription drug costs can impact the ability of physicians to place their patients on the best treatment regimen, due to the regimen being unaffordable for the patient, or being subject to coverage limitations and restrictions, as well as utilization management requirements, by the patient's health plan. In the worst-case scenario, patients entirely forgo necessary treatments involving drugs and biologics due to their high cost.

Increasing patient cost-sharing is associated with declines in medication adherence, which in turn can lead to poorer health outcomes. Among those currently taking prescription drugs, approximately a quarter of adults and seniors have reported difficulties in affording their prescription drugs. Approximately 30 percent of all adults have reported not taking their medications as prescribed at some point in the past year due to cost. Drilling down further, 16 percent of adults have not filled a prescription in the past year due to cost, 22 percent chose to take an over-the-counter medication instead, and 13 percent cut pills in half or skipped doses.[12]

Notably, out-of-pocket costs for prescription drugs are linked to the rate at which patients newly prescribed a drug either do not pick up their prescription or switch to another product. Many health plans have a formulary design with fixed copays for brand drugs of less than $30 for preferred products, with a rate of abandonment of 12 percent or less. For non-preferred brand drugs with a copay of $75, the rate of abandonment is 26 percent or higher. Fifty-six percent of prescriptions with a final cost of over $500 are not picked up by patients.[13]

LEVERAGING AN INTERNATIONAL PRICE INDEX IN MEDICARE PARTS B AND D

Proposals previously put forward by the Trump Administration and members of Congress attempted to lower US drug costs by tying them to international prices, and/or would have used an average of international prices, or an international reference price, to help define whether a price of a drug is excessive. While significant legislation addressing drug pricing has passed in the House of Representatives, negotiations have stalled following House passage. The Biden Administration has also stated that it will not implement a model utilizing an international price index in Medicare Part B without further rulemaking.

Current Status of Prescription Drug Price Negotiation in Medicare Parts D and B

The "noninterference clause" in the Medicare Modernization Act of 2003 (MMA) states that the Secretary of Health and Human Services (HHS) "may not interfere with the negotiations between drug manufacturers and pharmacies and [prescription drug plan] PDP sponsors, and may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs." Instead, participating Part D plans compete with each other based on plan premiums, cost-sharing and other features, which provides an incentive to contain prescription drug spending. To contain spending, Part D plans not only establish formularies, implement utilization management measures, and encourage beneficiaries to use generic and less-expensive brand-name drugs, but are

required under the MMA to provide plan enrollees access to negotiated drug prices. Similar to how drug prices are determined in other commercial plans available in the employer, individual and small-group markets, these prices are achieved through direct negotiation with pharmaceutical companies to obtain rebates and other discounts, and with pharmacies to establish pharmacy reimbursement amounts.

In efforts to lower drug prices and patient out-of-pocket costs in Medicare Part D, multiple bills have been introduced in Congress to enable and/or require the Secretary of HHS to negotiate covered Part D drug prices on behalf of Medicare beneficiaries. However, historically, the Congressional Budget Office (CBO), as well as Centers for Medicare & Medicaid Services (CMS) actuaries, have estimated that providing the Secretary of HHS broad negotiating authority by itself would not have any effect on negotiations taking place between Part D plans and drug manufacturers or the prices that are ultimately paid by Part D.[14,15]

In fact, CBO has previously acknowledged that, in order for the Secretary to have the ability to obtain significant discounts in negotiations with drug manufacturers, the Secretary would also need the "authority to establish a formulary, set prices administratively, or take other regulatory actions against firms failing to offer price reductions. In the absence of such authority, the Secretary's ability to issue credible threats or take other actions in an effort to obtain significant discounts would be limited."[16] CMS actuaries have concurred, stating "the inability to drive market share via the establishment of a formulary or development of a preferred tier significantly undermines the effectiveness of this negotiation. Manufacturers would have little to gain by offering rebates that are not linked to a preferred position of their products, and we assume that they will be unwilling to do so."[17]

The Council underscores that recent legislative and regulatory proposals that aimed to incorporate international drug price indices or averages in Medicare have targeted Part B in addition to Part D; therefore, it is imperative to understand how prices of Part B drugs are determined as well. Under current law, the Secretary of HHS also does not negotiate prices of and payment for Part B drugs. Instead, Medicare reimburses physicians and hospitals for the cost of Part B drugs at a rate tied to the average sales price (ASP) for all purchasers—including those that receive large discounts for prompt payment and high-volume purchases—plus a percentage of the ASP. Accordingly, any proposal to change how Part B drugs are priced—including the incorporation of international drug price indices and/or averages—also could significantly change how and the level at which physicians are paid for Part B drugs.

Recent Significant Legislative Developments

Legislation preceding Build Back Better, H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act, which passed the House of Representatives during the 116th Congress, would have opened the door to the Secretary of HHS to negotiate the prices of certain drugs. Title I of H.R. 3 would require the Secretary of HHS to directly negotiate with manufacturers to establish a maximum fair price for drugs selected for negotiation, which would be applied to Medicare, with flexibility for Medicare Advantage and Medicare Part D plans to use additional tools to negotiate even lower prices. Under H.R. 3, the Secretary of HHS would be required to negotiate maximum prices for: (1) insulin products; (2) with respect to 2023, at least 25 single-source, brand-name drugs that do not have generic competition and that are among either the 125 drugs that account for the greatest national spending or the 125 drugs that account for the greatest spending under the Medicare prescription drug benefit and Medicare Advantage (MA); (3) beginning in 2024, at least 50 such single-source, brand-name drugs; and (4) newly approved single-source, brand-name drugs with wholesale acquisition costs equal to or greater than the median household income. The negotiated

prices would be offered under Medicare and Medicare Advantage, as well as under private health insurance unless the insurer opts out. An "average international market price" would be established to serve as an upper limit for the price reached in any negotiation, if practicable for the drug at hand, defined as no more than 120 percent of the drug's volume-weighted net average price in six countries—Australia, Canada, France, Germany, Japan and the United Kingdom.[18]

Showing the impact of negotiating leverage, the December 10, 2019 CBO cost estimate "Budgetary Effects of H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act" stated that Title I of the legislation would reduce federal direct spending for Medicare by $448 billion over the 2020-2029 period.[19] In its October 11, 2019 estimate, CBO estimated that the largest savings would be the result of lower prices for existing drugs that are sold internationally, which would be impacted by the application of the "average international market price" outlined in the bill.[20] CBO also estimated that due to the collective provisions of H.R. 3, approximately eight fewer drugs would be introduced to the US market over the 2020-2029 period, with approximately 30 fewer drugs introduced to the US market over the following decade.[21] There would be a reduction of drugs introduced in the US market due to the enactment of H.R. 3 "because the potential global revenues for a new drug over its lifetime would decline as a result of enactment, and in some cases the prospect of lower revenues would make investments in research and development less attractive to pharmaceutical companies….The effects would be larger in the 2030s because of the considerable time needed to develop new drugs and because of the larger effects that would occur when more phases of development are affected."[22] In addition, CBO estimated that "[t]he introduction of new drugs would tend to be delayed in the six reference countries: Australia, Canada, France, Germany, Japan, and the United Kingdom. Prices of new drugs in those countries would rise somewhat."[23]

While H.R. 3 was reintroduced in this Congress, the latest congressional action on drug pricing was a part of H.R. 5376, the Build Back Better Act, which passed the House of Representatives in November 2021. If enacted into law, the House-passed version of Build Back Better would allow the Secretary of HHS to negotiate the prices of a small number of high-cost drugs covered under Medicare Part D (starting in 2025) and Part B (starting in 2027). The negotiation process would apply to no more than 10 single-source brand-name drugs or biologics that lack generic or biosimilar competitors in 2025, ramping up to no more than 20 in 2028 and later years. The drugs selected for negotiation would be required to be among the 50 drugs with the highest total Medicare Part D spending and the 50 drugs with the highest total Medicare Part B spending. All insulin products would also be subject to negotiation.[24]

Certain drugs would be exempt from negotiation, including those that are less than nine years (for small-molecule drugs) or 13 years (for biological products) from their U.S. Food and Drug Administration (FDA)-approval or licensure date. "Small biotech drugs" would also be exempt from negotiation until 2028; these drugs are defined as those which account for 1 percent or less of Part D or Part B spending and account for 80 percent or more of spending under each part on that manufacturer's drugs. In addition, the legislation exempts from negotiation drugs with Medicare spending of less than $200 million in 2021 (increased by the Consumer Price Index for All Urban Consumers (CPI-U) for subsequent years) and drugs with an orphan designation as their only FDA-approved indication.[25]

Due to lack of congressional support for incorporating international price indices/averages into the Medicare drug price negotiation process for drugs covered under Medicare Parts D and B, the Build Back Better Act as passed by the House of Representatives instead establishes an upper limit for the negotiated price (the "maximum fair price") equal to a percentage of the non-federal average manufacturer price (AMP)—the average price wholesalers pay manufacturers for drugs distributed to non-federal purchasers. The "maximum fair price" is defined as 75 percent of the

non-federal AMP for small-molecule drugs more than 9 years but less than 12 years beyond approval; 65 percent for drugs between 12 and 16 years beyond approval or licensure; and 40 percent for drugs more than 16 years beyond approval or licensure. The payment for Part B drugs selected for negotiation would be based on the maximum fair price, versus ASP under current law.[26] The Council underscores that at the time this report was written, there remains insufficient support in the House of Representatives and Senate to incorporate international price indices/averages into the Medicare drug price negotiation process for drugs covered under Medicare Parts D and B.

The significant differences between the drug negotiation provisions of the Build Back Better Act and H.R. 3 cause more limited cost savings and impacts on drug development under the Build Back Better Act. CBO estimated $78.8 billion in Medicare savings in the 2022-2031 period from the drug negotiation provisions in the Build Back Better Act. In addition, CBO estimated that one fewer drug would come to the US market over the 2022-2031 period, four fewer over the subsequent decade, and approximately five fewer the decade after that.[27]

Recent Regulatory Activity

The regulatory process is a pathway that cannot be ignored in its potential to change the way and level at which drugs are paid for under Medicare Part B through the incorporation of international drug price indices or averages. Notably, the AMA has been active in its advocacy efforts in response to regulatory proposals to date. In October of 2018, the Trump Administration released an Advance Notice of Proposed Rulemaking (ANPRM) entitled "International Pricing Index Model for Part B Drugs." The ANPRM did not represent a formal proposal, but rather outlined the Administration's thinking at the time, and sought stakeholder input on a variety of topics and questions related to this new drug pricing model prior to entering formal rulemaking. The ANPRM outlined a new payment model for physician-administered drugs paid under Medicare Part B that would transition Medicare payment rates for certain Part B drugs to lower rates that are tied to international reference prices—referred to as the "international pricing index"—except where the ASP is lower. The international reference price would partly be based on an average of prices paid by other countries. To accomplish this, the proposal would create a mandatory demonstration through the Centers for Medicare & Medicaid Innovation (CMMI), which would apply to certain randomly selected geographic areas, representing approximately 50 percent of Medicare Part B drug spending. Initially, the program would apply only to sole-source drug products and some biologics for which there is robust international pricing data available.

In geographic areas included in the demonstration, CMS would contract with private-sector vendors that would negotiate for, purchase, and supply providers with drug products that are included in the demonstration. CMS would directly reimburse the vendor for the included drugs, starting with an amount that is more heavily weighted toward the ASP instead of the international pricing index, and transitioning toward a target price that is heavily based on the international pricing index. Providers would select vendors from which to receive included drugs, but would not be responsible for buying from and billing Medicare for the drug product. Instead, providers would continue to be entitled to bill a drug administration fee, and would also be entitled to receive a drug add-on fee. While the ANPRM was somewhat short on detail on exactly how this add-on fee would be calculated, it appears the add-on fee would be a flat fee that is based on six percent of the historical average sales price for the drug in question.[28]

In September 2020, an executive order, "Lowering Drug Prices by Putting America First," was issued, and called for testing of payment models to apply international price benchmarking to Part B and Part D prescription drugs and biological products. For Part B, the executive order instructed

the Secretary of HHS to implement rulemaking to test a payment model under which "Medicare would pay, for certain high-cost prescription drugs and biological products covered by Medicare Part B, no more than the most-favored-nation price." The executive order defined the "most-favored-nation price" as "the lowest price, after adjusting for volume and differences in national gross domestic product, for a pharmaceutical product that the drug manufacturer sells in a member country of the Organisation for Economic Co-operation and Development (OECD) that has a comparable per-capita gross domestic product." For Part D, the executive order instructed the Secretary of HHS to develop and implement rulemaking to test a payment model for high-cost Part D drugs, limiting payment to these drugs to the most-favored-nation price, to the extent feasible.[29]

In November of 2020, the Trump Administration issued an interim final rule entitled "Most Favored Nation (MFN) Model" to establish a model through CMMI that would phase in changing Medicare's payment for approximately 50 Part B drugs that make up a high percentage of Part B spending from paying solely based on manufacturers' ASP to the lowest adjusted international price for the drug, defined as the lowest gross domestic product (GDP)-adjusted price paid by an OECD member country with a GDP per capita (based on purchasing power parity) that is at least 60 percent of the US GDP per capita. Addressing physician payment, the add-on payment based on six percent of ASP for the individual drug would be replaced with a flat payment per dose that would be uniform for all included drugs in the MFN Model. As the model was scheduled to become effective January 1, 2021, on December 28, 2020, the US District Court for the Northern District of California issued a nationwide preliminary injunction in *Biotechnology Innovation Organization v. Azar*, which preliminarily enjoined HHS from implementing the Most Favored Nation Rule. Given this preliminary injunction, the MFN Model was not implemented on January 1, 2021. The interim final rule was formally rescinded in December 2021 and will not be implemented without further rulemaking.[30]

RELEVANT AMA POLICY

AMA policy on prescription drug pricing is diverse, multifaceted, and allows the AMA to advocate on a breadth of issues to tackle high and escalating drug pricing, not limited to Medicare drug price negotiation or opening the door for the use of international drug price indices and averages in Medicare Parts D and B. This strong foundation of AMA policy addressing prescription drug pricing, coverage and payment has allowed the AMA to actively engage on legislative and regulatory proposals on drug pricing on both the federal and state levels.

Significantly, Policy H-110.987 supports legislation that limits Medicare annual drug price increases to the rate of inflation—a significant provision that has been included in recent legislation addressing prescription drug prices. The policy also supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations, as well as for biologics. The policy also supports drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10 percent or more each year or per course of treatment and provide justification for the price increase; legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10 percent or more each year or per course of treatment. In addition, it advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase. Finally, it states that our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for

innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.

Policy H-110.980[3] supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction. Policy D-100.983 outlines standards for the importation of prescription drug products. Policy H-110.986 supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.

Policy H-110.986 also supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. Finally, it supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including Hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.

Numerous policies aim to improve generic drug pricing and access. Policy H-110.988 states that our AMA will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the FDA, the U.S. Federal Trade Commission (FTC), and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs. The policy also states that our AMA will work with interested parties to support legislation to ensure fair and appropriate pricing of generic medications and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients. In addition, the policy encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs; and supports measures that increase price transparency for generic prescription drugs. Policy H-100.950 states that our AMA will advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek FDA and FTC approval before establishing a restricted distribution system; will support requiring pharmaceutical companies to allow for reasonable access to and purchase of appropriate quantities of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays; and will advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs. Policy H-110.989 supports: (1) the FTC in its efforts to stop “pay for delay” arrangements by pharmaceutical companies; and (2) federal legislation that makes tactics delaying conversion of medications to generic status, also known as “pay for delay,” illegal in the United States.

AMA policy also addresses other primary stakeholders in the prescription drug pricing arena, including pharmacy benefit managers (PBMs). Policy D-110.987 supports the active regulation of PBMs under state departments of insurance; supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to

drug prices at the point-of-sale; encourages increased transparency in how DIR fees are determined and calculated; and supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity. In addition, the policy outlines provisions to be disclosed as part of improved transparency of PBM operations.

Addressing the impact of prescription cost-sharing requirements on rates of prescription abandonment by patients, Policy H-125.979 contains significant AMA policy provisions promoting improved prescription drug formulary transparency, which address mid-year formulary changes, utilization management requirements and access to accurate, real-time formulary data at the point of prescribing. Policy D-155.994 advocates for third-party payers and purchasers to make cost data available to physicians in a useable form at the point of service and decision-making, including the cost of each alternate intervention, and the insurance coverage and cost-sharing requirements of the respective patient. Policy H-120.919 supports efforts to publish a Real-Time Prescription Benefit (RTPB) standard that meets the needs of physicians, utilizing any electronic health record, and prescribing on behalf of all patients.

AMA policy also recognizes that benefit design can be leveraged to ensure improved prescription drug cost-sharing affordability to promote improved patient adherence to prescribed medication regimens. Policy H-155.960 encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. The policy stipulates that consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance. Similarly, Policy H-110.990 states that cost-sharing requirements for prescription drugs should be based on considerations such as the unit cost of medication, availability of therapeutic alternatives, medical condition being treated, personal income, and other factors known to affect patient compliance.

Shifting to policies directly applicable to the referrals responded to by this report, Policy D-330.954 states that: (1) our American Medical Association (AMA) will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs; (2) our AMA will work toward eliminating Medicare prohibition on drug price negotiation; and (3) our AMA will prioritize its support for the Centers for Medicare & Medicaid Services (CMS) to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

Council on Medical Service Report 4-I-19 established a set of safeguards in AMA policy, now Policy H-110.980[2], pertaining to the use of international price indices and averages in determining the price of and payment for drugs. The following principles established in the policy are applicable to the pricing of prescription drugs under any health plan or proposal, and are not solely relevant to drugs covered under Medicare Part D, or even Medicare more broadly:

a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
c. The use of any international drug price index or average should preserve patient access to necessary medications;
d. The use of any international drug price index or average should limit burdens on physician practices; and
e. Any data used to determine an international price index or average to guide prescription drug pricing should be updated regularly.

Significantly, Policy H-110.980[1] advocates standards guiding the use of arbitration in determining the price of prescription drugs to lower the cost of prescription drugs without stifling innovation:

a. The arbitration process should be overseen by objective, independent entities;
b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.

Policy H-155.962 opposes the use of price controls in any segment of the health care industry and continues to promote market-based strategies to achieve access to and affordability of health care goods and services. Applicable to any vendor program that would be established in Medicare Part B to implement a pilot or permanent model implementing international price averages or indices, Policy H-110.983 advocates that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:

- it must be genuinely voluntary and not penalize practices that choose not to participate;
- it should provide supplemental payments to reimburse for costs associated with special handling and storage for Part B drugs;
- it must not reduce reimbursement for services related to provision/administration of Part B drugs, and reimbursement should be indexed to an appropriate health care inflation rate;
- it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of (CAP)-acquired drugs at multiple office locations;
- it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;
- it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician;
- it should not allow vendors to restrict patient access using utilization management policies such as step therapy; and
- it should not force disruption of current systems which have evolved to ensure patient access to necessary medications.

AMA ADVOCACY ON PRESCRIPTION DRUG PRICING

The Council understands that the introduction of original Resolution 113-N-21, as well as amendments made during consideration of Alternate Resolution 113-N-21, stemmed from strong support in the House of Delegates for the AMA to more actively and strongly advocate on the issue of prescription drug pricing. The AMA has been "at the table," advocating for the enactment of AMA policy pertaining to drug pricing with Congress via meetings with legislators and their staff as well as through letters and other communications. The AMA also has engaged the Administration through comment letters in response to regulatory activity as well as direct interactions and meetings. Finally, the AMA and members of the Federation have similarly advocated at the state level.

Showing the diversity and comprehensiveness of AMA policy and advocacy on drug pricing, the Council is providing a summary below to the House of Delegates of recent significant comments, letters and testimony addressing the introduction of and discussions surrounding prescription drug pricing legislation, and the promulgation of regulations addressing drug pricing.

- In March 2022, the AMA submitted a comment letter in response to the proposed rule outlining Medicare Advantage and prescription drug benefit policies for contract year 2023, in which the AMA supported the proposal to require the application of all pharmacy price concessions, including DIR fees, to drug prices in Medicare Part D at the point-of-sale.
- In August 2021, the AMA submitted a letter to congressional leadership to provide our perspective on health care issues related to the budget reconciliation proposal (Build Back Better). The letter supported efforts to eliminate prohibitions on the negotiation of prescription drug prices within the Medicare program and outlined AMA policy addressing the parameters of Medicare drug price negotiation, including the use of international drug price averages/indices, arbitration and value-based drug pricing. The letter also supported efforts to increase transparency in all aspects of the drug pricing process, as well as measures to address increases in prescription drug prices that exceed the rate of inflation. In addition, the letter outlined AMA policy on and support for efforts to cap patient out-of-pocket prescription drug expenses; pay-for-delay agreements between brand and generic drug manufacturers; and limit the use of drug utilization management tools by payers.
- In December 2020, the AMA submitted a comment letter in response to the MFN Model interim final rule, outlining significant concerns regarding the MFN Model and its impact on patient access to essential treatments, as well as the model's financial impact on physician practices.
- In March 2020, the AMA submitted a comment letter in response to the Importation of Prescription Drugs proposed rule.
- In February 2020, the AMA submitted a comment letter in response to released draft guidance regarding the importation of certain FDA-approved human prescription drug and biological products.
- In May of 2019, the AMA testified as part of the hearing before the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health titled, "Lowering Prescription Drug Prices: Deconstructing the Drug Supply Chain," submitting answers to follow-up questions after the hearing in August.
- In April 2019, the AMA submitted a comment letter in response to the proposed rule, "Removal of Safe Harbor Protections for Rebates Involving Prescription Pharmaceuticals and Creation of a New Safe Harbor Protection for Certain Point-Of-Sale Reductions in

Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees.

- In March 2019, the AMA submitted a letter to the leadership of the House Energy and Commerce Committee in support of its efforts, and pending legislation, to address the escalating prices of prescription medication by removing barriers to market entry for affordable prescription medication and shining a light on anticompetitive practices in the pharmaceutical supply chain that can lead to price escalations.
- In December 2018, the AMA submitted a comment letter in response to the ANPRM on an International Pricing Index Model (IPI model) for Medicare Part B Drugs, in which the AMA highlighted the need for significant reforms to the Medicare Part B competitive acquisition program (CAP) and the IPI model to ensure that beneficiaries have timely access to necessary treatments. The AMA also raised strong concerns with the proposed add-on formula, stating that "reimbursement models based on an 'add-on' formula are intended to adequately reimburse physicians for the costs of acquisition, proper storage and handling, and other administrative costs associated with providing these treatment options for patients. Many drugs included in this model, such as biological products, are complicated drug products that require special attention to handling and storage to remain stable and viable for administration to patients. Drugs that require specific conditions for shipping, storage, and handling result in significantly higher administrative costs to physician practices than many small molecule-type drugs. Due to the special nature of these products, these costs are fixed, and will not decrease as the price of the drug goes down. Given these fixed administrative costs, we are very concerned that, should drug prices decrease as this model predicts, any add-on payment based on an ASP would ultimately decrease with the price of the drug and would no longer be sufficient to cover the administrative costs to the practice. If add-on reimbursement decreases enough that it is no longer sufficient to cover the expenses associated with providing these treatment options, it is likely that practices will no longer be able to offer these options for patients. We strongly urge CMS to consider the impact on the add-on as the IPI model over time could reduce this amount below actual clinician cost."
- In July 2018, the AMA submitted a comment letter in response to *American Patients First, The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs* (Blueprint) Request for Information (RFI). In the letter, the AMA strongly supported a select number of Blueprint provisions to the extent that they would promote the following and recommended prompt regulatory action to: (1) require pharmaceutical supply chain transparency; (2) accelerate and expand regulatory action to increase pharmaceutical market competition and combat anti-competitive practices; (3) ensure prescribers have accurate point-of-care coverage and patient cost-sharing information as part of their workflow, including in the electronic health record; and (4) ensure federal programs and commercial practices billed as lowering prescription medication prices do so for patients directly. The AMA opposed Blueprint proposals that increased patient costs and erected barriers, including onerous insurer paperwork requirements that impede timely patient access to affordable and medically necessary medications and treatments. Further, the AMA opposed policies that would financially penalize physicians and pharmacists for high-cost prescription medication.

DISCUSSION

Since 2004, AMA Policy D-330.954 has supported giving the Secretary of HHS the authority to negotiate contracts with manufacturers of covered Part D drugs, and in 2017, formally prioritized AMA's support for the CMS to negotiate pharmaceutical pricing for all applicable medications covered by CMS. As previously referenced in the report, the CBO and CMS actuaries have

estimated that providing the Secretary of HHS broad negotiating authority by itself would not have any effect on negotiations taking place between Part D plans and drug manufacturers or the prices that are ultimately paid by Part D. In order for the Secretary to have the ability to obtain significant discounts in negotiations with drug manufacturers, CBO stated that the Secretary would also need the "authority to establish a formulary, set prices administratively, or take other regulatory actions against firms failing to offer price reductions."

Addressing the need for administrative leverage in Medicare drug price negotiations, the Council recognizes that incorporating international drug price indices and averages has become a popular proposal to significantly lower drug prices through said negotiations. However, the Council notes that recent legislative and regulatory proposals have not stopped at incorporating international prescription drug prices in Part D—they have extended to Medicare Part B, as well as to private health plans, unless they opt out. In fact, the proposal closest to being implemented in this arena has been via regulation, and solely addressing payment for prescription drugs in Medicare Part B. Therefore, AMA policy addressing the use of international drug price indices and averages in determining domestic drug prices needs to be consistent across not only all of Medicare, but across all health plans.

Recent legislative and regulatory proposals have not met the criteria established in Policy H-110.980, which guides AMA support for the use of international drug price averages/indices in determining domestic drug prices. Ultimately, the priority for the AMA in its advocacy efforts has been to preserve patient access to necessary medications, and limit burdens on and protect physician practices. While recent legislative and regulatory proposals have not met these and other important thresholds outlined in the policy, the Council believes that is not a reason to change AMA policy. In addition, the Council stresses that on the legislative front, at the time this report was written, there remains insufficient support in the House of Representatives and Senate to incorporate international price indices/averages into the Medicare drug price negotiation process for drugs covered under Medicare Parts D and B. Therefore, AMA policy moving forward needs to be able to respond to the more likely path to incorporate international drug price averages and/or indices in Medicare drug pricing—through regulation, targeting Medicare Part B drug payment.

The amendments proposed to Policy H-110.980 would have significant, negative, unintended consequences for the pricing of and payment for drugs under Medicare Part B, impacting patient access and physician practices. It also could set a dangerous precedent guiding the future payment of physician services. The Council instead firmly supports using arbitration as a lever in prescription drug price negotiations, including in Medicare, instead of a price ceiling based on international prices that does not meet existing policy principles. As such, the Council recommends the reaffirmation of Policy H-110.980. The Council also recommends the reaffirmation of Policy H-110.983, which advocates standards that any revised Medicare Part B Competitive Acquisition Program must meet, as a vendor program has often been proposed along with a model or new program to incorporate international drug price averages or indices in Medicare Part B.

To make patient cost-sharing obligations in the Medicare program more affordable, the Council believes that there is tremendous promise for models under the auspices of the CMMI to test the impact of offering Medicare beneficiaries additional enhanced alternative health plan choices that offer lower, consistent and predictable out-of-pocket costs for select prescription drugs. The Part D Senior Savings Model,[31] which is testing the impact of offering beneficiaries an increased choice of enhanced alternative Part D plan options that offer lower out-of-pocket costs for insulin, is a needed first step in the right direction.

On the whole, there is significant potential for other components of the AMA prescription drug pricing policy agenda to be implemented through legislation and/or regulations, and your Council believes that the focus of AMA advocacy efforts must continue to be multifaceted, diverse and nimble to achieve results for our patients and the physicians who provide their care. Medicare prescription drug price negotiation is only a piece of the larger drug pricing puzzle, which requires interventions to improve transparency and competition in the pharmaceutical marketplace; strengthen regulation of PBMs; limit drug price increases in Medicare to the rate of inflation; and ensure benefit design improves patient medication adherence.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of the second resolve of Alternate Resolution 113-N-21, as well as the referred amendment proffered during consideration of Alternate Resolution 113-N-21, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy D-330.954, which states that our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs; work toward eliminating Medicare prohibition on drug price negotiation; and prioritize its support for the Centers for Medicare & Medicaid Services (CMS) to negotiate pharmaceutical pricing for all applicable medications covered by CMS. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-110.980, which outlines principles to guide AMA support for arbitration as well as the use of international drug price averages/indices in determining domestic drug prices. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-110.983, which advocates standards that any revised Medicare Part B Competitive Acquisition Program must meet. (Reaffirm HOD Policy)

4. That our AMA encourage the development of models under the auspices of the CMS Innovation Center (CMMI) to test the impact of offering Medicare beneficiaries additional enhanced alternative health plan choices that offer lower, consistent, and predictable out-of-pocket costs for select prescription drugs. (New HOD Policy)

Fiscal note: Less than $500

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(A-22)

Introduced by: Young Physicians Section

Subject: Fertility Preservation Benefits for Active-Duty Military Personnel

Referred to: Reference Committee A

Whereas, According to Pentagon figures, over 200,000 women are in the active-duty U.S. military, including 74,000 in the Army, 53,000 in the Navy, 62,000 in the Air Force, and 14,000 in the Marine Corps in 2011;[1] and

Whereas, According to the U.S. Department of Veterans Affairs (VA), there were over 2 million women veterans as of September 2015;[2] and

Whereas, According to the 2012 Committee Opinion on "Health care for women in the military and women Veterans" from the American College of Obstetricians and Gynecologists (ACOG), "military service is associated with unique risks to women's reproductive health …. Obstetrician—gynecologists should be aware of high prevalence problems (e.g., posttraumatic stress disorder, intimate partner violence, and military sexual trauma) that can threaten the health and well-being of these women;"[3] and

Whereas, Both men and women in our U.S. military can suffer from infertility, sometimes directly as a result of blast traumas and spinal cord injuries;[4] and

Whereas, The U.S. Department of Defense (DOD) currently covers the cost of in vitro fertilization (IVF) and infertility services for certain injured active duty personnel;[5] and

Whereas, Under current Tricare policy, active-duty military personnel and their dependents have some limited coverage for infertility care and oocyte cryopreservation services at six specific military treatment facilities: Walter Reed National Military Medical Center in Bethesda MD; Womack Army Medical Center at Fort Bragg in Fayetteville NC; San Antonio Military Medical Center in San Antonio TX; San Diego Naval Medical Center in San Diego CA; Tripler Army Medical Center in Honolulu HI; Wright-Patterson Air Force Base Medical Center in Dayton OH; and Madigan Army Medical Center in Seattle-Tacoma WA;[6, 7] and

Whereas, This critical medical service is not fully available to active duty members of the military and those working with the DOD; and

Whereas, AMA Policy H-150.984 (3)(4) "Infertility Benefits for Veterans" states that: 3)"Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits through TRICARE and the VA at pre-deployment and during the medical discharge process. 4) Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries";[6] and

Whereas, Fertility preservation for medical indications (such as prior to cancer treatment, organ transplants, or treatment for rheumatologic diseases) are covered under the VA but not covered by the DOD; and

Whereas, AMA Policy H-185.990 "Infertility and Fertility Preservation Coverage," states that: "Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician;"[7] and

Whereas, AMA Policy H-185.922 "Right for Gamete Preservation Therapies" states that: "Our AMA supports insurance coverage for gamete preservation in any individual for whom a medical diagnosis or treatment modality is expected to result in the loss of fertility;" [8] therefore be it

RESOLVED, That our American Medical Association work with interested organizations to encourage TRICARE to cover fertility preservation procedures (cryopreservation of sperm, oocytes, or embryos) for medical indications, for active-duty military personnel and other individuals covered by TRICARE (Directive to Take Action); and be it further

RESOLVED, That our AMA work with interested organizations to encourage TRICARE to cover gamete preservation prior to deployment for active-duty military personnel (Directive to Take Action); and be it further

RESOLVED, That our AMA report back on this issue at the 2023 Annual Meeting of the AMA House of Delegates. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/17/22

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6. AMA policy H-510.984 on "Infertility Benefits for Veterans"
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8. AMA policy H-185.922 on "Right for Gamete Preservation Therapies"
9. AMA policy H-425.967 on "Disclosure of Risk to Fertility with Gonadotoxic Treatment"

RELEVANT AMA POLICY

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring

payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.
Citation: (Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14)

Disclosure of Risk to Fertility with Gonadotoxic Treatment H-425.967
Our AMA: (1) supports as best practice the disclosure to cancer and other patients of risks to fertility when gonadotoxic treatment is used; and (2) supports ongoing education for providers who counsel patients who may benefit from fertility preservation.
Citation: Res. 512, A-19

Right for Gamete Preservation Therapies H-185.922
Our AMA supports insurance coverage for gamete preservation in any individual for whom a medical diagnosis or treatment modality is expected to result in the loss of fertility.
Citation: Res. 005, A-19

Right for Gamete Preservation Therapies H-65.956
1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies.
Citation: Res. 005, A-19

Infertility Benefits for Veterans H-510.984
1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.
5. Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.
Citation: CMS Rep. 01, I-16; Appended: Res. 513, A-19

Veterans Administration Health System H-510.991
Our AMA supports approaches that increase the flexibility of the Veterans Health Administration to provide all veterans with improved access to health care services.
Citation: CMS Rep. 8, A-99; Reaffirmed: CMS Rep. 5, A-09; Reaffirmed: CMS Rep. 01, A-19

Health Care for Veterans and Their Families D-510.994
Our AMA will: (1) work with all appropriate medical societies, the AMA National Advisory Council on Violence and Abuse, and government entities to assist with the implementation of all recommendations put forth by the President's Commission on Care for America's Wounded

Warriors; and (2) advocate for improved access to medical care in the civilian sector for returning military personnel when their needs are not being met by resources locally available through the Department of Defense or the Veterans Administration.
Citation: (BOT Rep. 6, A-08; Reaffirmed: Sub. Res. 709, A-15)

Health Care Policy for Veterans H-510.990
Our AMA encourages the Department of Veterans Affairs to continue to explore alternative mechanisms for providing quality health care coverage for United States Veterans, including an option similar to the Federal Employees Health Benefit Program (FEHBP).
Citation: (Sub. Res.115, A-00; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)

Ensuring Access to Safe and Quality Care for our Veterans H-510.986
1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.
5. Our AMA supports access to clinical educational resources for all health care professionals involved in the care of veterans such as those provided by the U.S. Department of Veterans Affairs to their employees with the goal of providing better care for all veterans.
6. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed.
Citation: Res. 231, A-14; Reaffirmation A-15; Reaffirmed: Sub. Res. 709, A-15; Modified: Res. 820, I-18; Modified: Res. 305, I-19

Access to Health Care for Veterans H-510.985
Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of

Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.
Citation: Sub. Res. 111, A-15; Reaffirmed: CMS Rep. 06, A-17

Supporting Awareness of Stress Disorders in Military Members and Their Families H-510.988
Our AMA supports efforts to educate physicians and supports treatment and diagnosis of stress disorders in military members, veterans and affected families and continue to focus attention and raise awareness of this condition in partnership with the Department of Defense and the Department of Veterans Affairs.
Citation: Sub. Res. 401, A-10; Reaffirmed in lieu of: Res. 001, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(A-22)

Introduced by: New York

Subject: Bundling Physician Fees with Hospital Fees

Referred to: Reference Committee A

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1 Whereas, There is some thought about bundling the fees of physicians with those of the hospital
2 in which the services are provided; and
3
4 Whereas, Such “bundled” payments will go to the hospital which will then control the
5 payments; and
6
7 Whereas, Such a policy will likely make it not only harder for the physician to get paid, but also
8 much more dependent on the hospitals; and
9
10 Whereas, Hospitals would similarly never agree to bundled payments that went directly to
11 physicians; therefore be it
12
13 RESOLVED, That our American Medical Association oppose bundling of physician payments
14 with hospital payments, unless the physician has agreed to such an arrangement in advance.
15 (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 03/22/22

RELEVANT AMA POLICY

Health Care Reform Physician Payment Models D-385.963
1. Our AMA will: (a) work with the Centers for Medicare and Medicaid Services and other payers to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs; (b) develop guidelines for health care delivery payment systems that protect the patient-physician relationship; (c) make available to members access to legal, financial, and ethical information, tools and other resources to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems; and (d) work with Congress and the appropriate governmental agencies to change existing laws and regulations (eg, antitrust and anti-kickback) to facilitate the participation of physicians in new delivery models via a range of affiliations with other physicians and health care providers (not limited to employment) without penalty or hardship to those physicians.
2. Our AMA will: (a) work with third party payers to assure that payment of physicians/healthcare systems includes enough money to assure that patients and their families have access to the care coordination support that they need to assure optimal outcomes; and (b) will work with federal authorities to assure that funding is available to allow the CMMI grant-funded projects that have proven successful in meeting the Triple Aim to continue to provide the information we need to guide decisions that third party payers make in their funding of care coordination services.
3. Our AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Our AMA will provide information to members regarding AMA vetted legal and financial advisors and will seek discount fees for such services.
4. Our AMA will develop a toolkit that provides physicians best practices for starting and operating an

ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms. The toolkit will include legal governance models and financial business models to assist physicians in making decisions about potential physician-hospital alignment strategies. The toolkit will also include model contract language for indemnifying physicians from legal and financial liabilities.
5. Our AMA will continue to work with the Federation to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for others working to improve patient care and lower costs.
6. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
7. Our AMA will work with states to: (a) ensure that current state medical liability reform laws apply to ACOs and physicians participating in ACOs; and (b) address any new liability exposure for physicians participating in ACOs or other delivery reform models.
8. Our AMA recommends that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available.
9. Our AMA recommends that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health.
10. Our AMA encourages state and local medical societies to invite ACO and health department leadership to report annually on the population health status improvement, community health problems, recent successes and continuing problems relating to health risk reduction, and measures of health care quality in the state.
Citation: Sub. Res. 128, A-10; Appended: Res. 819, I-10; Appended: CMS Rep. 8, A-11; Appended: CMS Rep. 1, A-11; Reaffirmation A-11; Modified: BOT Rep. 18, A-12; Reaffirmation: I-12; Appended: Res. 702, A-13; Appended: Res. 827, I-14; Modified: Speakers Rep., I-15; Reaffirmed: CMS Rep. 09, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103
(A-22)

Introduced by: New York

Subject: COBRA for College Students

Referred to: Reference Committee A

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1 Whereas, The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a health insurance
2 program that allows an eligible employee and his or her dependents the continued benefits of
3 health insurance coverage in the case that an employee loses his or her job or experiences a
4 reduction of work hours; and
5
6 Whereas, COBRA allows former employees to obtain continued health insurance coverage at
7 group rates that otherwise might be terminated and which are typically less expensive than
8 those associated with individual health insurance plans; and
9
10 Whereas, Such COBRA coverage reduces the disruption, financial and otherwise, that could
11 occur when a person's employment is terminated; and
12
13 Whereas, College students enjoy similar group rate discounts with student health
14 insurance; and
15
16 Whereas, These students, upon graduation or other termination of an enrollment, potentially
17 face similar disruption in their healthcare coverage; therefore be it
18
19 RESOLVED, That our American Medical Association call for legislation similar to COBRA to
20 allow college students to continue their healthcare coverage, at their own expense, for up to
21 18 months after graduation or other termination of enrollment. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(A-22)

Introduced by: New York

Subject: Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for Health Care Financing

Referred to: Reference Committee A

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1 Whereas, Consumer Operated and Oriented Plans (CO-OPs) were enacted as a part of the
2 Affordable Care Act (ACA) to improve competition in the health care marketplace; and
3
4 Whereas, CO-OPs may improve the cooperation of patients, physicians, and other providers to
5 improve health outcomes while controlling costs; and
6
7 Whereas, CO-OPs were anticipated to have at least a 33% failure rate but have exceeded that
8 rate substantially; and
9
10 Whereas, CO-OP failures have been due in large part to a combination of premiums that were
11 too low, benefits that were too generous, enrollees who were sicker than anticipated,
12 competition from bigger carriers with larger reserves, changing regulations for risk corridor
13 payments, and restrictions on enrollments from large group markets; and
14
15 Whereas, Four of the original 23 CO-OPs have continued to operate despite these
16 challenges; and
17
18 Whereas, The remaining CO-OPs have had some success in reducing the cost of premiums,
19 but have limited market share and restrictions on enrollment; and
20
21 Whereas, Changing regulations or legislation to allow CO-OPs to more effectively compete in
22 the larger health insurance marketplace, further improve governance, further improve
23 operations, and stabilize the regulatory environment in which they operate may allow CO-OPs
24 to enhance competition in the broader health insurance market; therefore be it
25
26 RESOLVED, That our American Medical Association study options to improve the performance
27 of Consumer Operated and Oriented Plans (CO-OPs) as a potential public option to improve
28 competition in the health insurance marketplace and to improve the value of health care to
29 patients (Directive to Take Action); and be it further
30
31 RESOLVED, That our AMA work with the National Alliance of State Health Co-Ops to request
32 that Congress and the US Department of Health and Human Services reestablish funding for
33 new health insurance co-operatives. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(A-22)

Introduced by: New York

Subject: Health Insurance that Fairly Compensates Physicians

Referred to: Reference Committee A

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1 Whereas, There are increasing numbers of health insurance plans that do not adequately
2 compensate physicians for their services, including Medicaid, Medicare and many private
3 insurance plans; and
4
5 Whereas, Adequate insurance compensation is necessary for the continued independent
6 practice of medicine; and
7
8 Whereas, Hospitals and other groups providing medical goods and services would never accept
9 insurances that do not adequately compensate their services and products; therefore be it
10
11 RESOLVED. That our American Medical Association advocate for insurance plans to
12 adequately compensate physicians so that they are able to remain in practice independent of
13 hospital employment. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(A-22)

Introduced by: New York

Subject: Hospice Recertification for Non-Cancer Diagnosis

Referred to: Reference Committee A

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1 Whereas, The number of Americans ages 65 and older is projected to more than double from 46
2 million today to over 98 million by 2060; and
3
4 Whereas, The rate of dementia and failure to thrive at the end of life for older Americans is
5 increasing because of these demographic shifts; and
6
7 Whereas, The ability to predict the end of life is an art as opposed to a science; and
8
9 Whereas, These patients will need hospice care; therefore be it
10
11 RESOLVED, That our American Medical Association request that the Centers for Medicare &
12 Medicaid Services allow automatic reinstatement for hospice if a patient survives for more than
13 6 months with a non-cancer diagnosis and that prognosis remains terminal. (Directive to Take
14 Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(A-22)

Introduced by: New York

Subject: Medicaid Tax Benefits

Referred to: Reference Committee A

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1 Whereas, There are many patients with Medicaid or no health insurance that physicians care for
2 routinely for little or no payment; and
3
4 Whereas, It may be politically complicated to rectify this fact directly with improved payments to
5 physicians; and
6
7 Whereas, One way to offset the problem would be to use tax deduction techniques; and
8
9 Whereas, The AMA currently has contrary policy, H-180.965, “Income Tax Credits or
10 Deductions as Compensation for Treating Medically Uninsured or Underinsured,” that opposes
11 providing tax deductions or credits for the provision of care to the medically uninsured and
12 underinsured; therefore be it
13
14 RESOLVED, That our American Medical Association advocate for legislation that would allow
15 physicians who take care of Medicaid or uninsured patients to receive some financial benefit
16 through a tax deduction such as (a) a reduced rate of overall taxation or (b) the ability to use
17 the unpaid charges for such patients as a tax deduction. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

RELEVANT AMA POLICY

Income Tax Credits or Deductions as Compensation for Treating Medically Uninsured or Underinsured H-180.965
The AMA will not pursue efforts to have federal laws changed to provide tax deductions or credits for the provision of care to the medically uninsured and underinsured.
Citation: BOT Rep. 49, I-93; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed in lieu of Res. 141, A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(A-22)

Introduced by: New York

Subject: Payment for Regadenoson (Lexiscan)

Referred to: Reference Committee A

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1 Whereas, During exercise stress testing in cardiology, many patients are unable to walk on the
2 treadmill due to arthritis of knees and hips, PVD or deconditioning; and
3
4 Whereas, For such patients, a pharmacologic stress test is used to evaluate presence of
5 coronary artery disease using Regadenoson (Lexiscan) which is adenosine related
6 compound; and
7
8 Whereas, Cost of this agent from the supplier is around $248.00 for a single dose; and
9
10 Whereas, No insurance company including Centers for Medicare and Medicaid Services pays
11 the complete amount of $248.00; and
12
13 Whereas, Some HMOs like Fidelis and WellCare pay as little as $135.00, thus expecting the
14 stress test lab to absorb the loss of $110.00 each time such patient is tested; and
15
16 Whereas, This practice of underpaying by HMOs and insurance companies discourages stress
17 test labs to use Regadenoson for these patients due to significant financial loss; and
18
19 Whereas, The costs of other medical agents, such as vaccines and chemotherapy, are also not
20 adequately reimbursed; therefore be it
21
22 RESOLVED, That our American Medical Association petition the Centers for Medicare and
23 Medicaid Services to investigate the disparity between the cost of medical agents and the
24 reimbursement by insurance companies and develop a solution so physicians are not financially
25 harmed when providing medical agents. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(A-22)

Introduced by: New York

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

Referred to: Reference Committee A

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1 Whereas, According to the AMA Council on Medical Service (CMS), employers and insurance
2 companies are increasingly implementing programs (i.e., Financial Incentive Programs or FIPs)
3 that offer patients financial incentives when they use shopping tools to compare prices on health
4 care items and services and choose lower-cost options; and
5
6 Whereas, According to the CMS, empowering patients to pursue health care can minimize
7 financial burden and reduce societal health care costs; and
8
9 Whereas, According to the CMS, while considering these potential benefits of FIPs, it is critical
10 to ensure that patients are empowered to make fully informed decisions about their health care,
11 that they are never coerced into accepting lower-cost care if it could jeopardize their health, and
12 that programs that influence patient decision-making should be transparent about quality and
13 cost; and
14
15 Whereas, Multiple studies have shown that, on average, Medicaid recipients use emergency
16 rooms (ERs) more often than those with private insurance for non-urgent conditions; and
17
18 Whereas, Some states have implicated a copay system in an attempt to deter the overutilization
19 of ERs, but there is concern that such costs have been shown to cause people, especially those
20 within low-income and vulnerable populations, to forgo necessary care; and
21
22 Whereas, One multistate study found that charging higher copayments did not reduce ER use
23 by Medicaid recipients and reasons postulated for this finding include that copays are hard to
24 enforce, since ERs are legally obligated to examine anyone who walks through the doors,
25 whether or not they can pay; and
26
27 Whereas, One concept that has been implemented in a few states provides Medicaid recipients
28 with a prepaid card to cover a certain number of copays for ER visits and that any unutilized
29 amount on that copay card could be converted to a financial reward at the end of the year; and
30
31 Whereas, Some states have set up a 24-hour hotline staffed by nurses who can advise people
32 about whether they are having a true medical emergency; and
33
34 Whereas, There is also a compelling need to be very cautious regarding the creation of
35 disincentives for patients who are in need of care; therefore be it

1 RESOLVED, That our American Medical Association study and report on the positive and
2 negative experiences of programs in various states that provide Medicaid beneficiaries with
3 incentives for choosing alternative sites of care when it is appropriate to their symptoms and/or
4 condition instead of hospital emergency departments. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

RELEVANT AMA POLICY

Addressing Financial Incentives to Shop for Lower-Cost Health Care H-185.920
1. Our AMA supports the following continuity of care principles for any financial incentive program (FIP):
a. Collaborate with the physician community in the development and implementation of patient incentives.
b. Collaborate with the physician community to identify high-value referral options based on both quality and cost of care.
c. Provide treating physicians with access to patients' FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
d. Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
e. Provide referring and/or primary care physicians with the full record of the service encounter.
f. Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan).
g. Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans.
2. Our AMA supports the following quality and cost principles for any FIP:
a. Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
b. Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.
c. Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Differences in cost due to specialty or sub-specialty focus should be explicitly stated and clearly explained if data is made public.
d. Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
e. Provide a process through which patients and physicians can report unsatisfactory care experiences when referred to lower-cost physicians or facilities. The reporting process should be easily accessible by patients and physicians participating in the program.
f. Provide meaningful transparency of prices and vendors.
g. Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
h. Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs.
i. Methods of cost attribution to a physician or facility must be transparent, and the assumptions underlying cost attributions must be publicly available if cost is a factor used to stratify physicians or facilities.
3. Our AMA supports requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services.
4. Our AMA opposes FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice.
5. Our AMA encourages state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices.
6. Our AMA encourages objective studies of the impact of FIPs that include data collection on dimensions such as:
a. Patient outcomes/the quality of care provided with shopped services;

b. Patient utilization of shopped services;
c. Patient satisfaction with care for shopped services;
d. Patient choice of health care provider;
e. Impact on physician administrative burden; and
f. Overall/systemic impact on health care costs and care fragmentation.
Citation: CMS Rep. 2, I-19

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;
(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;
(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;
(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;
(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;
(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;
(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;
(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;
(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;
(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;
(12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;
(13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;
(14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;

(15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;
(16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;
(17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
(18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and
(19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.
Citation: BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21

Affordable Care Act Medicaid Expansion H-290.965
1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.
12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.
Citation: CMS Rep. 02, A-16; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 807, I-18; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(A-22)

Introduced by: New York

Subject: Private Payor Payment Integrity

Referred to: Reference Committee A

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1 Whereas, Private for-profit medical insurers often use self-developed payment guidelines to
2 their financial advantage in reducing or denying payment for necessary medical care; and
3
4 Whereas, For-profit private insurers have an unresolvable conflict of interest in denying payment
5 for diagnostic and treatment options approved by the FDA and adopted by CMS, Workers'
6 Compensation, auto liability insurance and other private payers and are considered medically
7 necessary by the patient and treating physician; therefore be it
8
9 RESOLVED, That our American Medical Association advocate for private insurers to require, at
10 a minimum, to pay for diagnosis and treatment options that are covered by government payers
11 such as Medicare (Directive to Take Action); and be it further
12
13 RESOLVED, That our AMA seek to ensure by legislative or regulatory means that private
14 insurers shall not be allowed to deny payment for treatment options as “experimental and/or
15 investigational” when they are covered under the government plans; such coverage shall extend
16 to managed Medicaid, Workers' Compensation plans, and auto liability insurance companies.
17 (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(A-22)

Introduced by: American Academy of Physical Medicine and Rehabilitation
Ohio

Subject: Bundled Payments and Medically Necessary Care

Referred to: Reference Committee A

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1 Whereas, Medicare operates bundled payment models that include several diagnoses, including
2 total knee replacement, total hip replacement, myocardial infarction, and others, where model
3 participants are responsible for managing the costs of all of the medical care furnished during
4 triggering admissions or procedures and for 90 days after discharge or 90 days after completion
5 of the procedure, with some exclusions; and
6
7 Whereas, State Medicaid programs are starting similar programs called Episodes of Care; and
8
9 Whereas, Even unrelated events (like cataract surgery or fractured hip from a fall) that occur
10 within 90 days after the initial hospital stay must be covered by the Medicare bundled payment;
11 and
12
13 Whereas, Some unrelated events can be very costly and cause significant spending beyond the
14 limits of the bundle which cannot be controlled by the initial physician; and
15
16 Whereas, One possible incentive for the physicians who are caring for the patient is to decrease
17 costs by decreasing access to services that the patient receives, regardless of the medical
18 needs of the patient, because the cost saved is returned to the physician/participant as a
19 financial bonus/payment; and
20
21 Whereas, Every patient is an individual with different responses to treatment and different
22 comorbidities; and
23
24 Whereas, Some patients need further therapy in an inpatient rehabilitation facility or skilled
25 nursing facility but are not offered those options due to cost containment; and
26
27 Whereas, In the absence of longitudinal care options such as care delivered in an inpatient
28 rehabilitation facility or skilled nursing facility, an overall increase in care per episode might
29 occur in some subpopulations with complications and comorbid conditions; therefore be it
30
31 RESOLVED, That our American Medical Association advocate that coverage rules for Medicaid
32 “Episodes of Care” be carefully reviewed to ensure that they do not incentivize limiting medically
33 necessary services for patients to allow better reimbursement for recipients of the bundled
34 payment (Directive to Take Action); and be it further
35
36 RESOLVED, That our AMA study the issue of “Bundled Payments and Medically Necessary
37 Care” with a report back to the AMA House of Delegates to explore the unintended long-term
38 consequences on health care expenditures, physician reimbursement, and patient outcomes
39 (Directive to Take Action); and be it further

1 RESOLVED, That our AMA advocate that functional improvement be a key target outcome for
2 bundled payments. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/31/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-22)

Introduced by: Maryland

Subject: Support for Easy Enrollment Federal Legislation

Referred to: Reference Committee A

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1 Whereas, In 2019, the Maryland General Assembly passed legislation to establish the Maryland
2 Easy Enrollment Health Insurance Program with strong support from MedChi, The Maryland State
3 Medical Society; and
4
5 Whereas, The easy enrollment legislation established a statewide mechanism for uninsured
6 people filing Maryland income tax returns to begin the process of enrolling into health coverage
7 by consenting, on their tax return, to have relevant information shared with the health insurance
8 exchange serving state residents; and
9
10 Whereas, A federalized version of the Maryland legislation, entitled the Easy Enrollment in
11 Health Care Act, has been introduced by Senator Chris Van Hollen (D-Maryland) and
12 Congressman Ami Bera, MD (D-California); and
13
14 Whereas, The Easy Enrollment in Health Care Act is supported by the American Academy of
15 Pediatrics, the American Heart Association, and many other stakeholders in health care; and
16
17 Whereas, The legislation will "establish a program which allows any taxpayer who is not
18 covered under minimum essential coverage at the time their return of tax for the taxable year is
19 filed, as well as any other household member who is not covered under such coverage, to, in
20 conjunction with the filing of their return of tax for any taxable year which begins after December
21 31, 2022, elect to—
22
23 (1) have a determination made as to whether the household member who is not
24 covered under such coverage is eligible for an insurance affordability program; and (2)
25 have such household member enrolled into minimum essential coverage;" and
26
27 Whereas, The legislation establishes appropriate limitations, including a prohibition on the
28 collection of information relating to citizenship, immigration status, and health status of any
29 household member; and
30
31 Whereas, The legislation will establish a process for the easy enrollment information to be
32 immediately transferred to relevant health insurance exchange and insurance affordability
33 programs "in order to increase the potential for immediate determinations of eligibility for and
34 enrollment in insurance affordability programs and minimum essential coverage;" and
35
36 Whereas, The legislation aligns with our AMA's mission to strive for the betterment of public
37 health; therefore be it

1 RESOLVED, That our American Medical Association advocate for the federal legislation known
2 as the Easy Enrollment in Health Care Act to allow Americans to receive health care information
3 and enroll in healthcare coverage through their federal tax returns. (Directive to Take Action)

References:

https://www.vanhollen.senate.gov/imo/media/doc/Easy%20Enrollment%20in%20Health%20Care%20Act%20[Final%20Bill%20Text].pdf

https://www.vanhollen.senate.gov/news/press-releases/van-hollen-bera-introduce-new-bicameral-bill-to-make-it-easier-for-americans-to-sign-up-for-health-care-close-massive-enrollment-gap

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/05/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(A-22)

Introduced by: Senior Physicians Section

Subject: Prevention of Hearing Loss-Associated-Cognitive-Impairment through Earlier Recognition and Remediation

Referred to: Reference Committee A

Whereas, Our AMA holds out as a primary objective "to promote the art and science of medicine and the betterment of public health;" and

Whereas, Our AMA has adopted policy in support of health promotion and preventive care, community preventive services, healthy lifestyles, coverage for preventive care and immunizations, health information and education, training in the principles of population-based medicine, values-based decision-making in the healthcare system, and encouragement of new advances in science and medicine via strong financial and policy support for all aspects of biomedical science and research;[1-8] and

Whereas, Our AMA has prior policy supporting insurance coverage for hearing remediation[9] as well as for dementia treatment;[10] and

Whereas, There is mounting evidence that there is a strong link between hearing impairment in middle and later life and the development of cognitive, as well as social impairments and falls, although its specific causality in relation to later cognitive loss has not yet conclusively been established;[11-31] and

Whereas, The landmark Lancet Commission on Dementia Prevention, Intervention and Care of 2017, amplified by the 2020 follow-up report[13-15] concluded that age-related hearing loss (ARHL) may account for nine percent of all cases of dementia, making this the single largest potentially modifiable risk factor for that condition, beginning in mid-life; and

Whereas, Compared to individuals with normal hearing, those individuals with a mild, moderate, and severe hearing impairment, respectively, have been shown to have a 2-, 3-, and 5-fold increased risk of incident all-cause dementia over 10 years of follow-up in one study;[29] and

Whereas, Based on prior and pilot studies,[30-31] the causative link between hearing impairment in middle age and later life to cognitive impairment is likely to be confirmed by ongoing ACHIEVE[32] and other clinical trials now in progress; and

Whereas, The return on investment for hearing remediation, especially but not exclusively in mid-life, will be substantial and time-sensitive because it may ameliorate (by delay in onset or even prevention of cognitive decline) far more costly care for those with cognitive decline (direct and indirect costs). Delaying the onset of Alzheimer's Disease by even one year has significant fiscal benefits. A 2014 study estimated a one-year delay in the onset of Alzheimer's disease would save the US $113 Billion by 2030. [33-40] This underscores the urgency of current action to reduce subsequent dementia related healthcare costs (perhaps especially, to Medicare) while simultaneously improving the quality of life of affected individuals; and

Whereas, A generally held calculation for the yearly cost of caring for those with dementia exceeds $307 billion as of 2010, and is expected to rise to $624 billion in 2030 and $1.5 trillion by 2050. The current yearly market cost of hearing aids in the US is estimated at $9 billion. This suggests that, with a 9% increase in risk of development of cognitive loss later in life due to unaddressed hearing loss,[13,15] remediating even this single important element linked to cognitive decline would be cost-effective immediately, and will be increasingly so in the future;[39,40] and

Whereas, The issue of hearing impairment is also a matter of health and social equity, with serious immediate and long-term consequences resulting from neglect of remediation. Unaddressed hearing loss reduces earnings potential and increases disability during gainful years, even before factoring in the likelihood of developing cognitive loss later. Sadly, the cost of hearing amplification and other forms of remediation is significant enough (even with over-the-counter products, which while possibly helpful do not come with professional guidance) to deter purchase and implementation by an indigent population;[46] and

Whereas, It is indisputable that promotion of any possibly effective means of delay, prevention, as well as timely treatment of cognitive impairment and dementia is highly desirable for public health, for humane as well as financial reasons; and

Whereas, Congress has shown interest in expanding coverage for hearing remediation in the most recent bill, HR 1118, 'Medicare Hearing Act of 2021,' filed in the current Congressional Session, affording a strategic opportunity for our AMA to more effectively advocate now for expanding coverage to include coverage of preventive strategies in middle age, by promoting this as a way to mitigate future Medicare costs;[41-43] and

Whereas, Some developed countries such as Brazil have launched national efforts to bring hearing remediation to the masses[45] as a means of reducing later cognitive decline, suggesting that early remediating of hearing is felt by other nations to be a cost-effective pursuit; and

Whereas, The issues involved in analyzing all factors impeding adequate distribution of hearing remediation are complex, and require physicians to be current, informed, and involved in the discussion with patients;[44,47-48] and

Whereas, A number of groups have a stake in promoting hearing remediation, including professional and citizen and Federal Agencies, such as the Agency for Health Research and Quality and the National Institute on Deafness and Other Communication Disorders (NIDCD); therefore be it

RESOLVED, That our American Medical Association promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment in later life, to physicians as well as to the public (Directive to Take Action); and be it further

RESOLVED, That our AMA promote, and encourage other stakeholders, including public, private, and professional organizations and relevant governmental agencies, to promote the conduct and acceleration of research into specific patterns and degrees of hearing loss to determine those most linked to cognitive impairment and amenable to correction (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for increased hearing screening, and expanding all avenues for third party coverage for effective hearing loss remediation beginning in mid-life or whenever detected, especially when such loss is shown conclusively to contribute significantly to the development of, or to magnify the functional deficits of cognitive impairment, and/or to limit the capacity of individuals for independent living. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/07/22

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8. H-450.938 Value-Based Decision-Making in the Health Care System
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114
(A-22)

Introduced by: Senior Physicians Section

Subject: Oral Healthcare IS Healthcare

Referred to: Reference Committee A

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1 Whereas, Nationwide, around 50% of Americans 65 and older lack any source of dental
2 insurance, and since its inception in 1965, Medicare has only covered dental care under
3 narrowly prescribed circumstances;[1] and
4
5 Whereas, Nearly half of Americans 65 and over didn't visit a dentist in the last year, citing
6 expense, (and 12% have not received dental care in five or more years). Nearly one in five have
7 lost all their natural teeth (even higher in black and non-Hispanic populations);[2] and
8
9 Whereas, Unaddressed tooth and gum disease dramatically increases the risks of
10 cardiovascular events such as heart attacks and stroke, and such events are leading causes of
11 death and disability in Medicare recipients, and there is a correlation between poor oral health
12 and chronic diseases more common in the elderly, such as diabetes and Alzheimer's, as well as
13 head and neck cancers;[3] and
14
15 Whereas, Prevention and treatment of dental diseases is effective in reducing many of these
16 adverse health consequences;[4] and
17
18 Whereas, Dental issues are a major source of pain, interfering directly with nutrition and
19 hydration, and painful dental infections are a common cause of emergency department visits,
20 some life threatening, requiring hospitalization and major expense; and
21
22 Whereas, In a 2019 AARP poll, 84 percent of Americans supported adding dental, vision and
23 hearing coverage to Medicare, even if their costs would increase;[5] and
24
25 Whereas, In all populations, including seniors, dental issues are a major source of both
26 economic as well as healthcare disparity;[6] and
27
28 Whereas, Expanded use of medication for Opioid Use Disorder has seen increasing prescription
29 of Suboxone in buccal or sublingual form, which delivery method has been shown to
30 dramatically increase the incidence of severe dental disease, including even loss of all teeth;[7-9]
31 and
32
33 Whereas, Congress is poised to consider Medicare expansion under various current and
34 pending proposals; therefore be it
35
36 RESOLVED, That our American Medical Association reaffirm that dental and oral health are
37 integral components of basic health care and maintenance regardless of age (Reaffirm HOD
38 Policy); and be it further

RESOLVED, That our AMA, through the Center for Health Equity, highlight the substantial contribution of dental and oral healthcare disparities to health inequity as well as to social and economic disparities (Directive to Take Action); and be it further

RESOLVED, That our AMA support ongoing research, legislative actions and administrative efforts to promote access to and adequate coverage by public and private payers for preventative and therapeutic dental services as integral parts of overall health maintenance to all populations (New HOD Policy); and be it further

RESOLVED, That our AMA work with other organizations to explore avenues to promote efforts to expand Medicare benefits to include preventative and therapeutic dental services, without additional decreases in Medicare Part B Reimbursements. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

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RELEVANT AMA POLICY

Medicare Coverage for Dental Services H-330.872
Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.
Citation: CMS Rep. 03, A-19;

Importance of Oral Health in Patient Care D-160.925
Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians.
Citation: Res. 911, I-16; Reaffirmed: CMS Rep. 03, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115
(A-22)

Introduced by: Illinois

Subject: Support for Universal Internet Access

Referred to: Reference Committee A

I. Issues of internet access as a human right

Whereas, The United Nations has declared internet access as a human right[1]; and

Whereas, The 2019 Broadband Deployment Report found that 21.3 million Americans lack home internet access[2]; and

Whereas, Home internet access varies by socioeconomic status, with only 64.3% of households that make less than $25,000 of annual income having access to internet as opposed to 93.5% of households with over $50,000 of annual income[3,4]; and

Whereas, One in three families who earn less than $50,000 annually do not have high-speed home internet[5]; and

II. Broadband as a social determinant of health

Whereas, The United States Congress defines broadband as a service that enables users to originate and receive high-quality voice, data, graphics, and video telecommunications[6]; and

Whereas, The 2020 FCC Broadband Deployment Report set the minimum service that qualifies as broadband at 25mbps upstream and 3mpbs downstream[7,8]; and

Whereas, Despite the FCC's Congressional mandate to "holistically evaluate progress in the deployment" of broadband, the FCC has declined to adopt benchmarks on affordability, data allowances, or latency for either fixed or mobile broadband services, because “[w]hile factors such as data allowances or pricing may affect consumers’ use of [broadband] or influence decisions concerning the purchase of these services in the first instance, such considerations do not affect the underlying determination of whether [broadband] has been deployed and made available to customers in a given area.”[7]; and

Whereas, Healthy People 2020 has identified internet access as a social determinant of health[9]; and

Whereas, Internet access is critical for receiving telehealth services, accessing childhood education, and applying for job opportunities, all of which contribute to health[10-13]; and

Whereas, During the current pandemic, telehealth and virtual education have become necessary to promote health and well-being[14]; and

Whereas, A majority of government applications for programs and benefits which affect health are available mostly or sometimes only online, especially during the COVID pandemic[12,13,15,16]; and

Whereas, Our AMA has committed itself to health equity and improving social determinants of health, stating in H-65.960 that "optimizing the social determinants of health is an ethical obligation of a civil society"; and

III. Broadband use in healthcare delivery

Whereas, The COVID pandemic has increased reliance on telehealth and has furthered the divide between patients with and without internet access[17]; and

Whereas, A study comparing the demographics of patients with completed telemedicine encounters in the current COVID-19 era at a large academic health system found that those with completed telemedicine video visits, when compared to telephone-only visits, were more likely to be male (50% versus 42%; P=0.01), were less likely to be black (24% versus 34%; P<0.01), and had higher median household income (21% versus 32% with income <$50 000, 54% versus 49% with income of $50 000–$100 000, 24% versus 19% with income ≥$100 000)[18]; and

Whereas, A study commissioned by the US Chamber of Commerce found broadband has helped to further broaden the scope of healthcare and has led to dramatic cost savings by facilitating the fast and reliable transmission of critical health information, multimedia medical applications, and lifesaving services to many parts of the country[19]; and

Whereas, Telemedicine has been demonstrated to allow for increased access to care, higher show rates, shorter wait times, increased clinical efficiency, and higher convenience – all affecting quality of patient care[20,21]; and

Whereas, Telemedicine has been demonstrated to reduce patient and healthcare worker exposure to COVID-19 among other diseases, reduce use of Personal Protective Equipment (PPE), and reduce use of hospital beds and other limited resources[14,20]; and

IV. Broadband use in education

Whereas, The COVID-19 pandemic caused a near-total shutdown of the U.S. school system, forcing more than 55 million students to transition to home-based remote learning[5]; and

Whereas, One in five households with school-age children (ages 6-18), including 1.6 million immigrant families, do not have personal broadband internet access at home during the COVID-19 pandemic[20,22]; and

Whereas, There are 4.6 million households with school aged children that access internet at home solely through cell phones, and 1.5 million households with school aged children who have no internet access of any kind at all, including cell phones[22]; and

Whereas, One in three Black, Latino, and American Indian/Alaska Native families do not have home internet access sufficient to support online learning during the COVID-19 pandemic[23]; and

V. COVID-19 pandemic has exacerbated disparities in internet access

Whereas, The United States internet usage has increased 34% between January 2020 and April 2020 during the COVID-19 pandemic[24]; and

Whereas, The FCC Lifeline program provides a choice between either discounted mobile internet access or discounted broadband access for qualifying low-income recipients[25]; and

Whereas, The FCC recognizes there is insufficient evidence to conclude that fixed and mobile broadband services are full substitutes in all cases[7]; and

Whereas, At least 21% of patients on Medicaid lack home internet access, accounting for approximately 15 of the estimated 21.3 million people that lack home internet access [26,27]; and

Whereas, The FCC Lifeline program is a discount program and not a free/fully subsidized program for which there is a significant backlog in applications and delay in application approvals, as well as a lack of an automatic application or automatic appeal process[25]; and

Whereas, During the COVID pandemic, after Lifeline expanded its capabilities, the program still only allows 1 stream of 25mbps per household, limiting access for households with more than one person working/attending school from home[28]; and

Whereas, In the 2020 legislative session as of October 2020, 43 states have considered legislation on broadband access[29]; and

Whereas, In 2020, multiple failed legislative efforts supported access to broadband internet in light of COVID pandemic, including the Emergency Broadband Benefit Program, which offered government subsidized free broadband service for COVID impacted people[30,31]; and

Whereas, It is probable that a stimulus package be proposed in the near future, which will likely include internet access as part of this package, between 2020 elections and the next meeting of the AMA House of Delegates[32,33]; and

Whereas, AMA policy H-478.980, “Increasing Access to Broadband Internet to Reduce Health Disparities,” sets precedent for the AMA advocating for internet access, and acknowledges the health benefit of internet access, but only asks for expansion of internet infrastructure in rural/underserved communities to provide “connectivity” rather than pushing for universal access to internet for those with significant limitations in access or financial constraints; and

Whereas, Universal coverage of home internet access would increase accessibility to this tool that is critical for patient health and public well-being; therefore be it

RESOLVED, That our American Medical Association recognize that internet access is a social determinant of health (New HOD Policy); and be it further

RESOLVED, That our AMA support universal access to broadband home internet (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for legislation to reduce barriers and increase access to broadband internet, including federal, state, and local funding of broadband internet to reduce price, the establishment of automatic applications for recipients of Medicaid or other assistance programs, and increasing the number of devices and streams covered per household. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/07/22

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RELEVANT AMA POLICY

Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980
Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.
Citation: Res. 208, I-18; Reaffirmed: CMS Rep. 7, A-21

Health, In All Its Dimensions, Is a Basic Right H-65.960
Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.
Citation: Res. 021, A-19

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers;

and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896
Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.
Citation: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19

National Health Information Technology D-478.995
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.
Citation: Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 3, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116
(A-22)

Introduced by: Medical Student Section

Subject: Reimbursement of School-Based Health Centers

Referred to: Reference Committee A

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1 Whereas, School Based Health Centers (SBHCs) are facilities located within the kindergarten
2 through twelfth grade school setting that provide an array of high-quality health care services to
3 students [1,2]; and
4
5 Whereas, SBHCs were first established in the 1960's by the American Academy of Pediatrics to
6 increase access to primary health care and preventative health services, especially for the most
7 vulnerable underserved population of children[3]; and
8
9 Whereas, Services available are driven by community need, ranging from primary medical care
10 to dental, vision, and behavioral health services, alongside wraparound programming such as
11 substance abuse counseling and social case management, and about 40% of SBHCs employ
12 physicians[1,2,4]; and
13
14 Whereas, The benefits of routine preventive care are well-established and are incredibly
15 important for children from infancy to adolescence, providing 1) prevention of serious medical
16 illnesses through vaccination and screening, 2) tracking growth and development, 3) raising
17 medical-related concerns, and 4) creating a strong patient-centered medical home[5]; and
18
19 Whereas, The SBHC model provides students with increased access to health care resources
20 and improved long- and short-term health care outcomes, including decreased emergency
21 department visits and hospital utilizations [3,6,7]; and
22
23 Whereas, SBHCs act as a "safety net health care delivery model" for uninsured, underinsured
24 children or those who lack accessible healthcare[8] ; and
25
26 Whereas, SBHCs can receive both grant funding by private organizations and the government,
27 and reimbursement for services rendered by a third-payer payer, most commonly Medicaid and
28 the Children's Health Insurance Program (CHIP); through private organizations;[9] or through
29 direct funding programs established by federal, state and local governments[10]; and
30
31 Whereas, The federally qualified health center (FQHC) program funds community health
32 centers that serve medically underserved populations, such as SBHCs, by providing cash
33 grants, drug discounts, legal protections, medical staff and, most uniquely, per-visit
34 reimbursement by Medicaid[11] ; and
35
36 Whereas, Funding SBHCs has been shown to be cost-effective by increasing access to
37 preventive care and reducing utilization of expensive acute care services, leading to a net
38 savings for Medicaid of $30 to $969 per visit[12]; and

Whereas, School-based health centers have grown substantially over the past two decades, primarily due to an increase in federally qualified health center (FQHC) sponsorship, with 2,584 SBHCs in the United States in 2017, more than double in number present in 1998, and since 2008, SBHC growth in urban areas has been greatly outpaced by growth in rural and suburban settings[13] ; and

Whereas, The majority of students without access to SBHCs attend schools in low-income communities eligible for Title I funding, and while increased FQHC sponsorship has greatly contributed to recent growth, 80% of FQHCs are not currently partnered with SBHCs[4]; and

Whereas, Many SBHCs rely on public funding,[9] although in 2014 only 89% of SBHCs billed Medicaid and 71% billed CHIP in 2014[4]; and

Whereas, Not all services rendered can be reimbursed under Medicaid at SBHCs, since among many requirements: 1) the child must be Medicaid-eligible, 2) the service must be among those covered by Medicaid and 3) the service must be provided by a Medicaid-participating provider - further, until 2014, reimbursement was not allowed for services given without charge to the beneficiary, except under rare exceptions[4,14,15] ; and

Whereas, Apart from seven state Medicaid agencies, SBHCs are not considered a provider type[16] making the reimbursement of services more difficult for SBHCs;

Whereas, The lack of differentiation on claims data means that Medicaid is unable to identify what services were rendered by an SBHC versus a different type of provider, making it difficult to track and attribute improvements in quality of care or outcomes to SBHCs, making it difficult for SBHCs to meet quality standards expected by the state[16]; and

Whereas, Multiple states have recently enacted policies that have facilitated or increased Medicaid reimbursement to SBHCs, with seven states (Delaware, Illinois, Louisiana, Maine, New Mexico, North Carolina, and West Virginia) naming SBHCs as a provider under Medicaid, four states (Louisiana, Maryland, Michigan, and New Mexico) mandating Medicaid reimbursement through a managed care organization, and eight states (Connecticut, Delaware, Illinois, Louisiana, Maine, Maryland, North Carolina, and West Virginia) waiving prior authorization[16]; and

Whereas, The AMA supports the study of SBHCs and recommends SBHC standards (H-60.991), supports adequately resourced SBHCs for healthcare delivery to children and adolescents (H-60.921), and supports physician service reimbursement and reimbursement for physician practices (H-240.966; H-385.990; H-385.942; 385.952); therefore be it

RESOLVED, That our American Medical Association amend Policy H-60.921, "School-Based and School-Linked Health Centers," by addition and deletion to read as follows:

School-Based and School-Linked Health Centers, H-60.921

1. Our AMA supports ~~the concept of adequately equipped and staffed~~ the implementation, maintenance, and equitable expansion of school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.

2. Our AMA recognizes that school-based health centers increase access to care in underserved child and adolescent populations.

3. Our AMA supports identifying school-based health centers in claims data from Medicaid and other payers for research and quality improvement purposes.

4. Our AMA supports efforts to extend Medicaid reimbursement to school-based health centers at the state and federal level, including, but not limited to the recognition of school-based health centers as a provider under Medicaid. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 04/08/22

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RELEVANT AMA POLICY

Providing Medical Services through School-Based Health Programs H-60.991

(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a

physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.
CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12

School-Based and School-Linked Health Centers H-60.921
Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.
CSAPH Rep. 1, A-15

Reimbursement to Physicians and Hospitals for Government Mandated Services H-240.966
(1) It is the policy of the AMA that government mandated services imposed on physicians and hospitals that are peripheral to the direct medical care of patients be recognized as additional practice cost expense.
(2) Our AMA will accelerate its plans to develop quantitative information on the actual costs of regulations.
(3) Our AMA strongly urges Congress that the RBRVS and DRG formulas take into account these additional expenses incurred by physicians and hospitals when complying with governmentally mandated regulations and ensure that reimbursement increases are adequate to cover the costs of providing these services.
(4) Our AMA will advocate to the CMS and Congress that an equitable adjustment to the Medicare physician fee schedule (or another appropriate mechanism deemed appropriate by CMS or Congress) be developed to provide fair compensation to offset the additional professional and practice expenses required to comply with the Emergency Medical Treatment and Labor Act.
Sub Res. 810, I-92; Appended by CMS 10, A-98; Reaffirmation: I-98; Reaffirmation: A-02; Reaffirmation: I-07; Reaffirmed in lieu of Res. 126, A-09; Reaffirmed: CMS Rep. 01, A-19

Payment for Physicians' Services H-385.990
Our AMA:
(1) Recognizes the validity of a pluralistic approach to third party reimbursement methodology and recognizes that indemnity reimbursement, as a schedule of benefits, as well as "usual and customary or reasonable" (UCR), have positive aspects which merit further study.
(2) Reaffirms its support for: (a) freedom for physicians to choose the method of payment for their services and to establish fair and equitable fees; (b) freedom of patients to select their course of care; and (c) neutral public policy and fair market competition among alternative health care delivery and financing systems.
(3) Reaffirms its policy encouraging physicians to volunteer fee information to patients and to discuss fees in advance of services, where feasible.
(4) Urges physicians to continue and to expand the practice of accepting third party reimbursement as payment in full in cases of financial hardship, and to voluntarily communicate to their patients through appropriate means their willingness to consider such arrangements in cases of financial need or other circumstances.
CMS Rep. B, I-83; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 137, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: BOT Rep. 10, I-05; Reaffirmed in lieu of Res. 127, A-10; Reaffirmed: CMS Rep. 01, A-20

CMS Use of Regulatory Authority to Implement Reimbursement Policy H-385.942
The AMA urge (1) CMS in the strongest terms possible to solicit the participation and counsel of relevant professional societies before implementing reimbursement policies that will affect the practice of medicine; (2) CMS to make every effort to determine the clinical consequences of such reimbursement policy changes before the revised policies are put in place; and (3) CMS in the strongest terms possible not to misapply either quality measurement data or clinical practice guidelines developed in good faith by the professional medical community as either standards or the basis for changes in reimbursement policies.
Res. 124, A-98; Modified and Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmed: Res. 105, A-18

Appropriate Physician Reimbursement by Centers for Medicare & Medicaid Services H-385.952
Our AMA: (1) opposes both CMS's and local carriers' efforts to reduce or deny physician payments for appropriate services; and (2) will work to assure that all evaluation and management services are appropriately reimbursed.
Res. 118, I-95; Reaffirmation: A-00; Reaffirmation: A-02; Reaffirmation: A-06; Reaffirmation: A-09; Reaffirmed: CMS Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117
(A-22)

Introduced by: Medical Student Section

Subject: Expanding Medicaid Transportation to Include Healthy Grocery Destinations

Referred to: Reference Committee A

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1 Whereas, Food insecurity is defined as the disruption of food intake or eating patterns due to
2 lack of money and other resources[1–5]; and
3
4 Whereas, Food insecurity increases the risk of developing chronic diseases such as obesity,
5 type II diabetes, and cardiovascular disease[1–7]; and
6
7 Whereas, Health care expenditures from 2011-2013 of food-insecure individuals were $1,863
8 higher per person compared to food-secure individuals, resulting in $77.5 billion of additional
9 health care spending[8]; and
10
11 Whereas, Medicaid eligibility is correlated with food insecurity and lack of access to grocery
12 stores[9]; and
13
14 Whereas, In 2015, 12.7% of the United States census tracts were categorized as low income
15 and were concurrently categorized as areas with limited access to a food store (supermarket,
16 grocery store)[10]; and
17
18 Whereas, In 2015, 18.2 million housing units were estimated to be in low-income census tracts
19 where at least 100 households without a vehicle lived more than half a mile from the nearest
20 supermarket or large grocery store, or where at least a third of the tract was more than 20 miles
21 from the nearest store[10]; and
22
23 Whereas, Over 9.5 million parents, 15.6 million nonparents, and 25.8 million children were
24 eligible for Supplemental Nutrition Assistance Program (SNAP) and Medicaid benefits in 2015[11];
25 and
26
27 Whereas, Individuals of lower socioeconomic status report inadequate geographical location of
28 food stores as a major barrier to proper nutrition, including inadequate transportation[12–15]; and
29
30 Whereas, Lack of access to supermarkets, as compared to relatively ready access to
31 convenience stores, can limit the availability of healthy foods, resulting in poorer health
32 outcomes, such as obesity or diabetes[16–20]; and
33
34 Whereas, There is extensive research to support that initiatives improving food access in low
35 income populations results in improved health outcomes[21–23]; and

Whereas, Non-emergency medical transportation services (NEMT) covered by State Medicaid includes transportation for prescriptions and medical supplies but not grocery stores, farmers markets, food banks or pantries[24,25]; and

Whereas, In the past 2 decades, various pilot programs in areas such as Los Angeles, California, north Nampa, Idaho and Flint, Michigan were initiated to provide transportation to and from specific grocery stores for residents in food deserts[23,26–29]; and

Whereas, A 10-week pilot program in Michigan's Upper Peninsula to improve food access, involving a local farmer's market and 32 patients with at least one chronic disease, motivation to begin a healthy lifestyle, and demonstrated difficulty in accessing fruits and vegetables, resulted in an increase of 1.2 cups of fruits and vegetables consumed per day and a significant increase in reported quality of life[22]; and

Whereas, Participants in an East Texas transportation voucher program that included grocery store access reported improved health and well-being, and were more likely to be aware of and utilize SNAP benefits[30]; and

Whereas, Pilot test healthy food access programs found that when barriers such as cost and access were removed, individuals from lower SES communities increased their purchase and consumption of fruits and vegetables[31,32]; and

Whereas, One study found that after a full-service supermarket was opened in a low-SES neighborhood, the rate of increase of diagnosed high cholesterol and arthritis incidence was reduced[33]; and

Whereas, Many pilot programs, such as LyftUp Grocery Access Program, run for a limited period of time, with ambiguity of future continuity, therefore offering only temporary aid[34,35]; and

Whereas, Medicaid has offered NEMT services since 1966 under the Code of Federal Regulations and authorized under the Social Security Act, providing 104 million healthcare-related trips at no cost to eligible individuals in 2013[24,36]; and

Whereas, NEMT costs Medicaid less than one percent of its total expenditures annually[37,38]; and

Whereas, Current AMA policy (D-150.978) encourages the "development of a healthier food system through tax incentive programs, community-level initiatives and federal legislation"; and

Whereas, Current AMA policy (H-130.954) only encourages the "development of non-emergency patient transportation systems… [for the accessibility] of health care", there is no policy that addresses the lack of transportation support to and from healthy grocery destinations; therefore be it

RESOLVED, That our American Medical Association: (1) support the implementation and expansion of transportation services for accessing healthy grocery options; and (2) advocate for inclusion of supermarkets, food banks and pantries, and local farmers markets as destinations offered by Medicaid transportation at the federal level; and (3) support efforts to extend Medicaid reimbursement to non-emergent medical transportation for healthy grocery destinations. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Date Received: 04/08/22

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RELEVANT AMA POLICY

Non-Emergency Patient Transportation Systems H-130.954

The AMA: (1) supports the education of physicians and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.
Res 812, I-93; Reaffirmed: CMS Rep 10, A-03; Reaffirmed in lieu of Res 101, A-12; Modified: CMS Rep 02, I-18

Food Environments and Challenges Accessing Healthy Food H-150.925

Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; (2) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; and (3) supports policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food.
Res 921, I-18; Modified: Res. 417, A-21

Improvements to Supplemental Nutrition Programs H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.

2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.
Res 414, A-10; Reaffirmed A-12; Reaffirmation A-13; Appended: CSAPH Rep 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res 407, A-17; Appended: Res 233, A-18

Sustainable Food D-150.978
Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through tax incentive programs, community-level initiatives and federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems.
CSAPH Rep. 8, A-09; Reaffirmed in lieu of Res. 411, A-11; Reaffirmation: A-12; Reaffirmed in lieu of Res. 205, A-12; Modified: Res. 204, A-13; Reaffirmation: A-15

Medicare's Ambulance Service Regulations H-240.978
1. Our AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to the most appropriate facility based on the patient's needs and the determination made by physician medical direction; and expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the onsite evaluation and physician medical direction.
2. Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) to pay emergency medical services providers for the evaluation and transport of patients to the most appropriate site of care not limited to the current CMS defined transport locations.
Res 37, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep 3, A-08; Modified: Res 124, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 118
(A-22)

Introduced by: Medical Student Section, Endocrine Society

Subject: Caps on Insulin Co-Payments for Patients with Insurance

Referred to: Reference Committee A

Whereas, Diabetes affects approximately 9.4% of the U.S. population and is the seventh leading cause of death nationally[1,2]; and

Whereas, Direct medical costs for diagnosed diabetes were estimated at $327.2 billion in 2017, with nearly $102 billion lost due to lower productivity resulting from diabetes[3]; and

Whereas, The annual average medical cost per person with diabetes is $13,240 with approximately 44% of expenditures stemming from prescription medications, including insulin[4]; and

Whereas, From 2012 to 2016, the average point-of-sale price of insulin nearly doubled from 13 cents per unit to 25 cents per unit, translating to a daily cost increase from $7.80 to $15 for a patient with Type 1 diabetes using an average amount of insulin (60 units per day)[5]; and

Whereas, One in four patients reported cost-related insulin underuse, including taking smaller doses and skipping doses, which was independent of the patient's prescription drug coverage plan[6]; and

Whereas, Patients who report cost-related underuse were more likely to have poor glycemic control, which is associated with an increased risk for complications such as hypertension, chronic kidney disease, neuropathy, lower limb amputations, retinopathy, stroke, coronary heart disease, depression, and cancer[6,7]; and

Whereas, Seven states have approved legislation on insulin copayment caps since April 2020, instituting a $35-$100 maximum copayment for a 30-day insulin supply[8]; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) plans to limit insulin prescription costs through Medicaid Part D for the 2021 plan year to a maximum $35 copay for a 30-day supply, and estimate annual out-of-pocket savings per patient to be reduced by 66%[9]; and

Whereas, Individual and family savings resulting from caps on insulin copayments have the potential to alleviate financial burden[10]; and

Whereas, The AMA has policy consistent with the principle of increasing access to prescription medications including insulin for patients[11-16]; and

Whereas, Some private insurance programs have shown the capability to offer a capped copayment on insulin for their customers, without any increased cost to their insurance premium or plan[17]; therefore be it

RESOLVED, That our American Medical Association amend Policy H-110.984, "Insulin Affordability," by addition to read as follows:

Insulin Affordability H-110.984
Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; ~~and~~ (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies~~.~~; and (3) support state and national efforts to limit the copayments insured patients pay per month for prescribed insulin. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 04/08/22

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RELEVANT AMA POLICY

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980
1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
a. The arbitration process should be overseen by objective, independent entities;
b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
c. The use of any international drug price index or average should preserve patient access to necessary medications;
d. The use of any international drug price index or average should limit burdens on physician practices; and
e. Any data used to determine an international price index or average to guide prescription drug pricing should be updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.
CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20

Insulin Affordability H-110.984
Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; and (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.
CMS Rep. 07, A-18

Pharmaceutical Costs H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic

manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.
Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988
1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.

2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.
3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.
4. Our AMA supports measures that increase price transparency for generic prescription drugs.
Sub. Res. 106, A-15: Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 2017, A-17; Reaffirmed: BOT Rep. 14, A-18

Cost of Prescription Drugs H-110.997
Our AMA:
(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;
(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;
(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;
(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;
(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;
(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and
(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.
Citation: BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep.3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

Reducing Prescription Drug Prices D-110.993
Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.

CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation: A-14; Reaffirmed in lieu of Res. 229, I-14

Prescription Drug Prices and Medicare D-330.954
1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.
Citation: Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 113, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 119
(A-22)

Introduced by: Medical Student Section

Subject: Medicare Coverage of Dental, Vision, and Hearing Services

Referred to: Reference Committee A

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1 Whereas, The Social Security Act expressly prohibits coverage for most dental services,
2 specifically "services in connection with the care, treatment, filling, removal, or replacement of
3 teeth or structures directly supporting teeth," by Original Medicare for its beneficiaries[1]; and
4
5 Whereas, Though Medicare covers "medically necessary" dental care, the Centers for Medicare
6 & Medicaid Services presently interprets this to cover a very limited scope of services and
7 coverage determinations are often inconsistent--for example, Medicare Part A will cover an oral
8 examination as part of a comprehensive workup in preparation for a kidney transplant, but not
9 for transplantation of non-kidney organs[2,3]; and
10
11 Whereas, Almost 24 million Medicare beneficiaries have no dental coverage, comprising nearly
12 half of Medicare beneficiaries[4]; and
13
14 Whereas, In 2021, 16.6 million Medicare Advantage enrollees have some dental benefits
15 through their plans, but 78% of those with coverage are enrolled in plans with annual dollar
16 limits on dental coverage (average annual limit of $1,300), 10% are required to pay an
17 additional premium for dental coverage, and plans with coverage for extensive dental services
18 often necessitate significant coinsurance cost-sharing (most common cost-sharing of 50%)[4];
19 and
20
21 Whereas, Lack of dental coverage and dental underinsurance leads to Medicare beneficiaries
22 forgoing recommended care, with 47% of those enrolled in Medicare not visiting the dentist in
23 2018[4]; and
24
25 Whereas, Racial inequities are perpetuated in access to dental services, with Black and
26 Hispanic Medicare enrollees most likely to have not seen a dentist in the past year (68% and
27 61%, respectively)[4]; and
28
29 Whereas, Only 7.27% of Medigap (Medicare Supplement) plans offer additional benefits such
30 as dental, hearing, and vision coverage[5]; and
31
32 Whereas, A 2016 analysis of over 1,200 older adult respondents in the Health and Retirement
33 Study found that only 68% used dental services, and two-thirds of those who wanted to use
34 dental services but did not do so reported cost as a reason they did not receive dental care[6];
35 and
36
37 Whereas, The 2016 analysis of the Health and Retirement Study found that 42% of those using
38 dental services received a filling, bonding, or inlay; 34% received a crown, implant, or prosthetic;
39 26% received a gum treatment, tooth extraction, or surgery; and 10% received dentures[6]; and

Whereas, Poor dental health has myriad negative repercussions for patients' health, including nutritional deficiencies secondary to tooth loss, exacerbation of diabetes and cardiovascular disease by untreated caries and periodontal disease, infections, and delayed diagnoses resulting in preventable complications and adverse outcomes, including for cancer[7,8]; and

Whereas, Original Medicare does not cover routine eye examinations or refractions for eyeglasses or contact lenses, nor does it cover eyeglasses or contact lenses themselves other than eyeglasses following cataract surgery[2,9]; and

Whereas, Untreated vision loss is correlated with increased risk of falls, depression, cognitive impairment, hospitalization, and mobility limitations among older adults[10]; and

Whereas, Thirty-nine percent of Medicare beneficiaries reported having trouble seeing even with their glasses, and low-income beneficiaries were most likely to have vision trouble[10]; and

Whereas, Among Medicare beneficiaries, forty-three percent who have difficulty seeing have not had an eye exam within the last year[11]; and

Whereas, Only thirty-seven percent of Medicare beneficiaries over the age of 65 had an eye exam at least once every 15 months in one recent study[12]; and

Whereas, Medicare beneficiaries with supplemental vision plans spent an average of $415 for vision care, while those with Medicare Advantage spent an average of $331, with 61% and 65% of spending being comprised of out-of-pocket costs to the patient, indicating that even those who have some vision care have significant out-of-pocket expenses for vision care[10]; and

Whereas, Medicare beneficiaries hospitalized for common illnesses were shown to have longer mean lengths of stay, higher readmission rates, and higher costs both during hospitalization and ninety days post-discharge if they had partial or severe vision loss compared to matched hospitalized Medicare beneficiaries with no vision loss, resulting in an estimated $500 million in excess healthcare costs annually[13]; and

Whereas, Among Medicare beneficiaries, low vision is associated with an increased risk of hip fractures, depression, anxiety, and dementia, and more prevalent among Black and Hispanic patients[14]; and

Whereas, Medicare beneficiaries with vision impairment reported lower well-being, which was found to be mediated by limitations on mobility and household activities/ instrumental activities of daily living relative to Medicare patients without visual impairment[15]; and

Whereas, A 2018 study published in *JAMA Ophthalmology* found that Hispanic and Black Medicare beneficiaries were significantly less likely to report using low-vision devices than white patients, but there were no similar disparities for low-vision rehabilitation (which is covered by Medicare), leading the study authors to conclude that "policy makers could consider expanding Medicare coverage to include low-vision devices in an effort to address significant disparities in the use of this evidence-based intervention"[16]; and

Whereas, Among adults over the age of 65, the prevalence of falls in the past year for patients with vision impairment was over double that for patients without vision impairment (27.6% versus 13.2%), and the prevalence of activity restriction due to fear of falling was much higher in patients with vision impairment as well (50.8% versus 33.9% for patients without vision impairment)[17]; and

Whereas, A 2017 *JAMA Ophthalmology* study indicated that visual impairment was associated with a 1.9- to 2.8-fold increase in cognitive dysfunction or dementia among adults 60 years and older[18]; and

Whereas, A study of over 22,000 nationwide respondents to the Medicare Current Beneficiary Study found that beneficiaries with vision impairment were significantly more likely to be hospitalized over a three-year period[19]; and

Whereas, Nearly 25% of people aged 65-74 and 50% persons of people over 75 suffer from disabling hearing loss, which is associated with decreased quality of life, increased risk of cognitive decline and hospitalization, and higher healthcare costs by thousands of dollars, outweighing the relative cost of providing hearing services[20-24]; and

Whereas, Fewer than 30% of those aged 70 and older who could benefit from hearing aids have ever used them, with many reporting cost as prohibitive, with an average cost of $2,500 for a pair of digital hearing aids and some ranging up to $6,000[25-26]; and

Whereas, Original Medicare does not cover hearing exams, hearing aids, or aural rehabilitative services, while Medicare Advantage charges additional premiums for hearing coverage, with out-of-pocket costs and annual limits varying significantly across Advantage plans[27-28]; and

Whereas, The *Lancet* Commission has recognized hearing impairment as one of the most important modifiable risk factors for dementia, and observed that “hearing aid use was the largest factor protecting from decline” and “the long follow-up times in these prospective studies suggest hearing aid use is protective, rather than the possibility that those developing dementia are less likely to use hearing aids”[29]; and

Whereas, Medicare beneficiaries with functional hearing difficulty (which reflects perceived hearing under daily circumstances and takes the use of hearing aids into account for patients that have them) experience more unmet healthcare needs, such that study investigators concluded that “rethinking service delivery models to provide better access to hearing care could lead to increased hearing aid use and improved interactions between providers and patients with hearing loss”[30]; and

Whereas, AMA Policy H-185.929, “Hearing Aid Coverage,” supports Medicare covering hearing tests, but does not indicate support for hearing aids or aural rehabilitative services (which includes fittings and adjustments); and

Whereas, Numerous recent proposals from the legislative and executive branches have proposed the creation of new dental benefits for preventive and restorative services and additional vision and hearing benefits for routine exams and aids under Medicare Part B, including President Biden’s 2022 budget request, legislation (H.R. 3) passed by the House of Representatives in 2019, and most recently, the Senate Democrats’ budget resolution[5,31,32]; therefore be it

RESOLVED, That our American Medical Association support Medicare coverage of preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures (New HOD Policy); and be it further

RESOLVED, That our AMA support Medicare coverage of routine eye examinations and visual aids, including eyeglasses and contact lenses (New HOD Policy); and be it further

RESOLVED, That our American Medical Association amend Policy H-185.929, “Hearing Aid Coverage,” by addition to read as follows:

Hearing Aid Coverage H-185.929

1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team<u>, aural rehabilitative services, and hearing aids</u> as part of Medicare's Benefit.
5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

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RELEVANT AMA POLICY

Eye Exams for the Elderly H-25.990

Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings.
Res. 813, I-05; Reaffirmed: CSAPH Rep. 1, A-15

Hearing Aid Coverage H-185.929

1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.

CMS Rep. 6, I-15; Appended: Res. 124, A-19

Medicare Coverage for Dental Services H-330.872

Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.
CMS Rep. 03, A-19

Importance of Oral Health in Patient Care D-160.925

Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians.
Res. 911, I-16; Reaffirmed: CMS Rep. 03, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 120
(A-22)

Introduced by: American Thoracic Society

Subject: Expanding Coverage for and Access to Pulmonary Rehabilitation

Referred to: Reference Committee A

Whereas, Pulmonary Rehabilitation is defined as: “a comprehensive intervention based on a thorough patient assessment followed by patient-tailored therapies that include, but are not limited to, exercise training, education, and behavior change, designed to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health-enhancing behaviors (1);” and

Whereas, Pulmonary Rehabilitation has been shown to have numerous benefits for patients with chronic respiratory disease, including measurable physiologic benefits, reduction in symptoms of shortness of breath, psychosocial benefits, and economic benefits (2); and

Whereas, Pulmonary Rehabilitation has been shown to be effective for numerous conditions, including COPD and sequelae of acute COVID-19 infection (3,4); and

Whereas, Pulmonary Rehabilitation is a cost-effective intervention with benefits to the health care system in addition to individual patients (5); and

Whereas, While many physicians prescribe pulmonary rehabilitation programs for their patients with a wide variety of respiratory diseases and symptoms, patients often struggle to obtain insurance coverage for these services; and

Whereas, Improved insurance coverage of Pulmonary Rehabilitation programs would lead to proliferation of such programs, which is difficult for many patients to find; therefore be it

RESOLVED, That our American Medical Association advocate for insurance coverage for and access to pulmonary rehabilitation for any patient with chronic lung disease or chronic shortness of breath. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 121
(A-22)

Introduced by: Society of Critical Care Medicine

Subject: Increase Funding, Research and Education for Post-Intensive Care Syndrome

Referred to: Reference Committee A

Whereas, AMA Policy D-460.965, “Call for Increased Funding, Research and Education for Post Viral Syndromes,” asks for coding and funding for the post-acute sequelae of COVID-19; and

Whereas, The COVID-19 pandemic has substantially increased the number of patients requiring critical care; and

Whereas, After critical illness, new or worsening impairments in physical, cognitive, and/or mental health function are common among patients who survive, independent of virally driven mechanisms; and

Whereas, There is attention and heightened interest by both the public and medical communities to understand post-COVID effects, with new terminologies being used such as “long-COVID,” “long-haul COVID” and “Chronic COVID” which includes patients with COVID discharged from the ICU; and

Whereas, Post-intensive care syndrome (PICS) is a defined term which the critical care community is using in research, diagnosis and treatment and thus already captures an important population of post-COVID patients making it topical to more formally define via ICD-10 codes and work efforts; and

Whereas, One-quarter to one-half or more of critical illness survivors will suffer from some component of PICS, including muscle weakness, poor mobility, poor concentration, poor memory, fatigue, anxiety, and depressed mood, which are typically corroborated by examination and formal testing; and

Whereas, Although recovery is possible, many of the signs and symptoms of PICS last for months to years, increasing health care utilization, particularly within the first 90 days of discharge (1); and

Whereas, Only with specific ICD-10 codes can primary care physicians and health systems be adequately recognized through risk adjustment for taking care of this population with increased needs; and

Whereas, Current relevant ICD-10 codes are limited to G72.81, Critical illness myopathy, and F43.1, Post-traumatic stress disorder, which do not encompass the breadth or specificity of symptoms experienced by patients with PICS; therefore be it

1 RESOLVED, That our American Medical Association support the development of an ICD-10
2 code or family of codes to recognize Post-Intensive Care Syndrome (PICS) (New HOD Policy);
3 and be it further
4
5 RESOLVED, That our AMA advocate for legislation to provide funding for research and
6 treatment of PICS, including for those cases related to COVID-19. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 122
(A-22)

Introduced by: Michigan

Subject: Medicaid Expansion

Referred to: Reference Committee A

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1 Whereas, The Affordable Care Act, which beneficially expanded health insurance coverage in
2 the United States, allowed states to determine if they wished to enact Medicaid Expansion; and
3
4 Whereas, Lack of insurance coverage has devastating effects on the health of all persons,
5 affecting them, their families, and society in general; and
6
7 Whereas, Medicaid expansion in the states in which it has been enacted has been
8 demonstrated to have beneficial effects on the health status of enrollees and to save money;
9 therefore be it
10
11 RESOLVED, That our American Medical Association continue to advocate strongly for
12 expansion of the Medicaid program to all states and reaffirm existing policies D-290.979,
13 H-290.965 and H-165.823 (Directive to Take Action); and be it further
14
15 RESOLVED, That our AMA produce informational brochures and other communications that
16 can be distributed by health care professionals to inform the public of the importance of
17 expanded health insurance coverage to all. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

RELEVANT AMA POLICY

Medicaid Expansion D-290.979
Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.
Citation: Res. 809, I-12; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

Affordable Care Act Medicaid Expansion H-290.965
1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.

2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.
12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.
Citation: CMS Rep. 02, A-16; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 807, I-18; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, I-21

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823
1. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
e. The public option is financially self-sustaining and has uniform solvency requirements.
f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

2. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
3. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.
Citation: CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 123
(A-22)

Introduced by: Illinois

Subject: Advocating for All Payer Coverage of Cosmetic Treatment for Survivors of Domestic Abuse and Intimate Partner Violence

Referred to: Reference Committee A

Whereas, The CDC reports that 1 in 4 women and 1 in 10 men 18 years of age or older experience intimate partner violence (IPV)[1,2]; and

Whereas, Domestic violence accounts for over 20% of all violent victimizations[3]; and

Whereas, Nearly half of all domestic and IPV cases result in injury, the most common of which are physical burns and cuts[3]; and

Whereas, International organizations have reported a significant increase in reports of IPV since the onset of the COVID-19 pandemic[4–7]; and

Whereas, Acquired facial trauma is associated with a higher likelihood of negative social and functional outcomes including lower self-esteem and higher rates of depression, post-traumatic stress disorder, anxiety disorders, alcohol use disorder, and unemployment[8,9]; and

Whereas, Women were more likely to use self-pay to cover IPV-related medical care than to use private insurance prior to the implementation of the Affordable Care Act[11]; and

Whereas, Private insurer claims data have shown a rise in the use of private health insurance to cover IPV-related emergency department visits[11]; and

Whereas, Many private insurers do not cover medical expenses for cosmetic treatments to injuries that are not considered to provide a gain in functional outcomes; and

Whereas, Cosmetic procedures may reduce the incidence of re-lived experiences of psychological trauma by eliminating physical reminders of the acquired disfigurement; therefore be it

RESOLVED, That our American Medical Association urge all payers to consider aesthetic treatments for physical lesions sustained from injuries of domestic and intimate partner violence as restorative treatments (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders such as medical specialty societies, third party payers, the Centers for Medicare and Medicaid Service, and other national stakeholders as deemed appropriate to require third party payers to include reimbursement for necessary aesthetic service for the treatment of physical injury sustained along with medically necessary restorative care for victims of domestic abuse. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 05/02/22

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3. Truman JL. Nonfatal Domestic Violence, 2003-2012. Published online 2014:21.
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RELEVANT AMA POLICY

Definitions of "Cosmetic" and "Reconstructive" Surgery H-475.992

(1) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer.
Citation: (CMS Rep. F, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed, A-03; Reaffirmed: CMS Rep. 4, A-13)

Insurance Discrimination Against Victims of Domestic Violence H-185.976

Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence.
Citation: Res. 814, I-94; Appended: Res. 419, I-00; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19;

Family and Intimate Partner Violence H-515.965

(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To suppor physicians in practice, our AMA will continue to campaign against

family violence and remains open to working with all interested parties to address violence in US society.
(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.
(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.
(4) Within the larger community, our AMA:
(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.
(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.
(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the

laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.
(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:
(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.
Citation: CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep. 2, I-09; Modified: CSAPH Rep. 01, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 124
(A-22)

Introduced by: Illinois

Subject: To Require Insurance Companies Make the “Coverage Year” and the “Deductible Year” Simultaneous for Their Policies

Referred to: Reference Committee A

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1 Whereas, Health care insurance is expensive, and consumers pay high deductibles for their
2 medical care; and
3
4 Whereas, When a consumer pays his/her deductible, he/she expects the deductible to cover the
5 remainder of the coverage year; and
6
7 Whereas, Many health insurance companies count the “coverage year” from the date the policy
8 becomes effective and the “deductible year” from January 1 of each year; and
9
10 Whereas, A consumer whose policy begins mid-calendar year, and who pays the full deductible
11 for care before January 1 when the new “deductible year” begins, is not receiving a full year of
12 benefit for the full deductible he/she paid; and
13
14 Whereas, Insurance companies have sophisticated computer systems to track the “deductible
15 year” and the “coverage year” for each consumer; therefore be it
16
17 RESOLVED, That our American Medical Association advocate and support legislation to require
18 all commercial insurance carriers to align their policies such that a policy holder’s “deductible
19 year” and “coverage year” be the same time period for all policies. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 05/02/22

RELEVANT AMA POLICY

Deductibles Should Be Prorated to Make Them Equitable for Enrollees H-180.955
Our AMA seeks legislation, regulation or other appropriate relief to require insurers to prorate annual deductibles to the date of contract enrollment.
Citation: Res. 235, A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT Rep. 7, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 125
(A-22)

Introduced by: Senior Physicians Section

Subject: Education, Forewarning and Disclosure regarding Consequences of Changing Medicare Plans

Referred to: Reference Committee A

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1 Whereas, 1 in 4 senior physicians with regular Medicare insurance already have a Medicare
2 Supplement Insurance or "Medigap," policy[1]; and
3
4 Whereas, Some Seniors who enroll in Medicare Advantage plans are not able to use Medigap
5 insurance for their cost sharing and therefore stop paying their Medigap premiums; and
6
7 Whereas, If seniors decide to disenroll from Medicare Advantage and return to regular
8 Medicare, they may: (1) have difficulty getting a Medigap plan and may have to provide medical
9 information to qualify to purchase it; (2) may not be able to get the same Medigap plan they had
10 before; and/or (3) need to pay a higher premium for their new Medigap policy; and
11
12 Whereas, Most seniors with Medicare have an overwhelming number of plans from which to
13 choose from when turning 65 years of age: Medicare vs. Medicare Advantage, Medicare
14 supplemental policies, and Medicare Part D policies and without guidance to help them
15 understand the intricacies of transitioning from one plan to another, seniors can find themselves
16 with less robust coverage than they need; and
17
18 Whereas, It may not be widely appreciated that Medicare switching costs increase if you take
19 Medicare Advantage and then decide to go back to Medicare; and
20
21 Whereas, Under current programs being investigated by CMS' Center for Medicare and
22 Medicaid Innovation, beneficiaries may be funneled involuntarily into accountable care
23 organizations without warning or instructions on how they might opt out; therefore be it

RESOLVED, That our American Medical Association amend policy H-330.870, “Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans,” by addition and deletion to read as follows:

Our AMA will: (1) advocate for provision of transparent print and audio/video patient educational resources to patients and families in multiple languages from health care systems and from Medicare - directly accessible - by consumers and families, explaining clearly the different benefits, as well as the varied, programmatic and other out-of-pocket costs for their medications under Medicare, Medicare Supplemental and Medicare Advantage plans ~~on their personal costs for their medications under Medicare and Medicare Advantage plans - both printed and online video - which health care systems could provide to patients and which consumers could access directly~~; and

(2) advocate for printed and audio/video patient educational resources regarding personal costs, changes in benefits and provider panels that may be incurred when switching (voluntarily or otherwise) between Medicare, Medical Supplemental and Medicare Advantage or other plans, including additional information regarding federal and state health insurance assistance programs that patients and consumers could access directly; and

(~~2~~3) ~~support~~ advocate for increased funding for federal and state health insurance assistance programs and educate physicians, hospitals, and patients about the availability of and access to ~~these~~ such programs. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/03/22

REFERENCE

(1) Boccuti, C., Jacobson, G., Orgera, K., & Neuman, T. (2018). Medigap enrollment and consumer protections vary across states. Kaiser Family Foundation.

RELEVANT AMA POLICY

Medicare Advantage Policies H-285.913

Our AMA will:
1. pursue legislation requiring that any Medicare Advantage policy sold to a Medicare patient must include a seven-day waiting period that allows for cancellation without penalty;
2. pursue legislation to require that Medicare Advantage policies carry a separate distinct page, which the patient must sign, including the statement, "THIS COVERAGE IS NOT TRADITIONAL MEDICARE. YOU HAVE CHOSEN TO CANCEL YOUR TRADITIONAL MEDICARE COVERAGE; NOT ALL PHYSICIANS, HOSPITALS AND LABORATORIES ACCEPT THIS NEW MEDICARE ADVANTAGE POLICY AND YOU MAY PERMANENTLY LOSE THE ABILITY TO PURCHASE MEDIGAP SECONDARY INSURANCE" (or equivalent statement) and specifying the time period before they can resume their traditional Medicare coverage; and
3. petition the Centers for Medicare and Medicaid Services to implement the patient's signature page in a Medicare Advantage policy.

Citation: Res. 907, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmation: I-18

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930

Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate

physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.
Citation: BOT Action in response to referred for decision Res. 711, I-06; Reaffirmation A-08; Modified: CMS Rep. 01, A-19

Legislation for Assuring Equitable Participation of Physicians in Medicare Advantage H-330.916
Our AMA seeks to have the CMS, while contracting with Medicare Advantage organizations for Medicare services, require the following guarantees to assure quality patient care to medical beneficiaries: (1) a Medicare Advantage patient shall have the right to see a duly licensed physician of the appropriate training and specialty; (2) if CMS decertifies a Medicare Advantage plan, enrollees in that plan who are undergoing a course of treatment by a physician at the time of such termination shall continue to receive care from their treating physician until an appropriate transfer is accomplished; and (3) any Medicare Advantage plan deselection of participating physicians may occur only after the physician has been given the opportunity to appeal the deselection decision to an Independent Review Body.
Citation: Res. 707, I-98; Reaffirmed: BOT Rep. 23, A-09; Modified: CMS Rep. 01, A-19

Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans H-330.870
Our AMA will: (1) advocate for transparent patient educational resources on their personal costs for their medications under Medicare and Medicare Advantage plans--both printed and online video--which health care systems could provide to patients and which consumers could access directly; and (2) support increased funding for federal and state health insurance assistance programs and educate physicians, hospitals, and patients about the availability of these programs.
Citation: Res. 817, I-19

Medicare Advantage Opt Out Rules H-330.913
Our AMA: (1) opposes managed care "bait and switch" practices, whereby a plan entices patients to enroll by advertising large physician panels and/or generous patient benefits, then reduces physician reimbursement and/or patient benefits, so that physicians leave the plan, but patients who can't must choose new doctors; (2) supports current proposals to extend the 30 day waiting period that limits when Medicare recipients may opt out of managed care plans, if such proposals can be amended to create an exemption to protect patients whenever a plan alters benefits or whenever a patient's physician leaves the plan; and (3) supports changes in CMS regulations which would require Medicare Advantage plans to immediately notify patients, whenever such a plan alters benefits or whenever a patient's physician leaves the plan, and to give affected patients a reasonable opportunity to switch plans.
Citation: Res. 707, A-99; Reaffirmed: CMS Rep. 5, A-09; Modified: CMS Rep. 01, A-19

Support for Seamless Physician Continuity of Care H-390.836
Our AMA encourages physicians who encounter contractual difficulties with Medicare Advantage (MA) plans to contact their Centers for Medicare & Medicaid Services (CMS) Regional office.
Citation: BOT Action in response to referred for decision Res. 816, I-16

Reference Committee B

BOT Report(s)

09 Council on Legislation Sunset Review of 2012 House Policies

17 Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession

Resolution(s)

201 The Impact of Midlevel Providers on Medical Education
202 AMA Position on All Payer Database Creation
203 Ban the Gay/Trans (LGBTQ+) Panic Defense
204 Insurance Claims Data
205 Insurers and Vertical Integration
206 Medicare Advantage Plan Mandates
207 Physician Tax Fairness
208 Prohibit Ghost Guns
209 Supporting Collection of Data on Medical Repatriation
210 Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits
211 Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program
212 Medication for Opioid Use Disorder in Physician Health Programs
213 Resentencing for Individuals Convicted of Marijuana-Based Offenses
214 Eliminating Unfunded or Unproven Mandates and Regulations
215 Transforming Professional Licensure to the 21st Century
216 Advocating for the Elimination of Hepatitis C Treatment Restrictions
217 Preserving the Practice of Medicine
218 Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas
219 Due Process and Independent Contractors
220 Vital Nature of Board-Certified Physicians in Aerospace Medicine

REPORT OF THE BOARD OF TRUSTEES

B of T Report 9-A-22

Subject: Council on Legislation Sunset Review of 2012 House Policies

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee B

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

1. As the House of Delegates (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.

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RECOMMENDATION

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

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-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 Act to Prohibit the Criminalization of Healthcare Decision-Making." (Res. 228, I-98; Reaffirmed: BOT Rep. 5, A-08; Reaffirmation: I-12)	Retain – this policy remains relevant.
D-185.986	Third Party Payer Coverage Process Reform and Advocacy	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. 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	Retain – this policy remains relevant.

		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. 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. (Res. 820, I-11; Appended: Res. 807, I-12)	
D-190.984	HIPAA	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. (Res. 901, I-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)	Retain – this policy remains relevant.
D-190.988	HIPAA interference with Peer Review Activities	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. (Res. 721, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)	Sunset this policy. 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.
D-190.989	HIPAA Law And Regulations	(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. ~~(2) If satisfactory modification to the~~	Retain and modify part of this policy. Rescind clause 2 and 3, and renumber and modify clause 4. Clause 2 is outdated and no longer applicable. Regarding clause 3, opposing unique patient

		~~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.~~ ~~(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.~~ ~~(4)~~(2) Our AMA shall ~~immediately begin working~~ continue to work 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~~ associated with HIPAA compliance so as to reduce the fiscal burden on physicians. (Sub. Res. 207, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)	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.
D-230.991	Inspector General to Rule on Exclusivity Restrictions for Medical Staff Membership	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. (Res. 714, I-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)	Retain – this policy remains relevant.
D-235.987	Medical Staff Bylaws as Binding Contracts	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. (Sub. Res. 818, I-12)	Sunset this policy. 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 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	Retain – this policy remains relevant.

		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)	
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 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	Retain – this policy remains relevant.

		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. (Res. 219, A-11; Appended: Res. 218, A-12)	
D-383.984	ERISA and Managed Care Oversight	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. (Res. 915, I-06; Reaffirmed: Res. 223, I-10; Reaffirmed: CMS Rep. 6, A-12)	Retain – this policy remains relevant. 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.
D-390.986	Medicare Balance Billing	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. (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)	Retain – this policy remains relevant.
D-478.984	Clinical Data Repositories for Physicians, Patients	Our American Medical Association will (1) collect and make available the best practices resulting from existing pilot Clinical Data Repository (CDR) projects	Retain – this policy remains relevant.

	and Continuous Quality Improvement	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. (BOT Rep. 3, I-09; Reaffirmed in lieu of Res. 704, A-12)	
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. (Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12)	Retain – this policy remains relevant.
H-165.841	Comprehensive Health System Reform	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. (Sub. Res. 924, I-07; Reaffirmed: Res. 239, A-12)	Sunset this policy. This has been accomplished through the Affordable Care Act and superseded by more recent policy, H-165.838.

H-175.985	Kennedy-Kassebaum: Fraud and Abuse	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; (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; (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; (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; (6) educates the public and government officials about the distinction under the law, between inadvertent billing errors and fraud and abuse; and (7) responds vigorously to any public statements that fail to distinguish between inadvertent billing errors and fraud and abuse. (Sub. Res. 222, A-97; Appended: Res. 202, I-98; Reaffirmation A-99;	Retain – this policy remains relevant.

		Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, A-12)	
H-175.989	Health Care Fraud Legislation	Our AMA: (1) should continue to scrutinize current and future key legislation regarding health care fraud and abuse; (2) should use all appropriate resources available to ensure that any proposed sanctions, penalties, or sentences be commensurate with the offense committed, 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; (3) should work with appropriate federal agencies and congressional committees in studying the extent to which health care fraud pervades the current environment; (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; (5) should conduct surveys and research in order to develop data on possible abuses in the system; (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; (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; (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 (9) continue to make the relief of oppressive and overzealous application	Sunset this policy. 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. Also, the HOD has adopted more current and relevant policy addressing fraud and abuse since 1992, including: H-175.979, Medicare "Fraud and Abuse" Update; H-175.981, Fraud and Abuse Within the Medicare System; H-175.982, Due Process for Physicians; H-175.984, Health Care Fraud and Abuse Update; H-70.952, Medicare Guidelines for Evaluation and Management Codes

		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. (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)	
H-180.954	Privacy of Physician Medical Information	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. (BOT Rep. 7, I-02; Reaffirmed: CMS Rep. 4, A-12)	Retain – this policy remains relevant.
H-190.960	HIPAA Law and Regulations	Our AMA believes that inadvertent disclosures of protected health information should not lead to the imposition of criminal sanctions. (Sub. Res. 207, A-02; Reaffirmed: CMS Rep. 4, A-12)	Retain – this policy remains relevant.
H-285.909	Designation of Electrodiagnosis / Other Services as Separate Category in Provider Network	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 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)	Retain – this policy remains relevant.
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.	Retain – this policy remains relevant. Primary care physicians should not be required by health plans to authorize alternative medicine that they do not provide

		(Res. 702, A-98; Reaffirmed: BOT Rep. 36, A-02; Reaffirmed: CMS Rep. 4, A-12)	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.	Retain – this policy remains relevant.

		(BOT Rep. MMM, A-91; Reaffirmation A-97; Reaffirmation I-06; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12)	
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 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)	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.
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	Retain – this policy remains relevant.

		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)	
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.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-A-22

Subject: Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee B

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]

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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 under subsequent state legalization of adult use or medicinal cannabis. (New HOD Policy)

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. (New HOD Policy)

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. (Directive to Take Action)

4. That AMA Policy D-95.960, "Public Health Impacts of Cannabis Legalization" be rescinded since this report fulfills the directive contained in the policy. (Rescind HOD Policy)

Fiscal Note: $5000.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(A-22)

Introduced by: Resident and Fellow Section

Subject: The Impact of Midlevel Providers on Medical Education

Referred to: Reference Committee B

Whereas, A survey in 2017 published in Worldviews Evidence Based Nursing revealed that a majority of the 2,300 nurse respondents did not feel competent in evidence-based practice[1]; and

Whereas, Physicians that speak out about the differences in training received by physicians vs. by mid-level providers are being fired, labeled “disrespectful” or labeled “not team players” in the interdisciplinary team treating patients[1]; and

Whereas, More non-physician post-graduate training programs are being formed across the nation; there is still no mandatory requirement for non-physicians to pursue post-graduate training[1]; and

Whereas, Physicians are expected to continue to maintain certification by proving they continue to educate themselves; mid-level providers are not held to the same standard[1]; and

Whereas, Currently mid-level providers can switch between specialties and subspecialties of medicine and surgery without any formal or regulated training or education[1]; and

Whereas, Physicians are limited in their practice abilities by the post-graduate training they receive[1]; therefore be it

RESOLVED, That our American Medical Association study, using surveys among other tools that protect identities, how commonly bias against physician-led healthcare is experienced within undergraduate medical education and graduate medical education, interprofessional learning and team building work and publish these findings in peer-reviewed journals (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to ensure all physician undergraduate and graduate training programs recognize and teach physicians that they are the leaders of the healthcare team and are adequately equipped to diagnose and treat patients independently only because of the intensive, regulated, and standardized education they receive (Directive to Take Action); and be it further

RESOLVED, That our AMA study the harms and benefits of establishing mandatory postgraduate clinical training for nurse practitioners and physician assistants prior to working within a specialty or subspecialty field (Directive to Take Action); and be it further

RESOLVED, That our AMA study the harms and benefits of establishing national requirements for structured and regulated continued education for nurse practitioners and physician assistants in order to maintain licensure to practice. (Directive to Take Action)

Fiscal Note: Estimated cost of $50,000 to implement resolution.

Received: 04/04/22

References:

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(A-22)

Introduced by: New York

Subject: AMA Position on All Payer Database Creation

Referred to: Reference Committee B

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1 Whereas, Organized medicine worked hard to push for the creation of the FAIRHEALTH
2 database, an independent database of charges; and
3
4 Whereas, Private health insurers are now pushing for legislation to create alternate databases
5 at the state and federal levels known as an All Payer Database; and
6
7 Whereas, The All Payer Database will reflect payments from all payers and as such will be
8 heavily weighted towards poor payments for physicians such as Medicare and Medicaid which
9 are generally lower payments than issued by commercial and self-insured plans; and
10
11 Whereas, Much of this information is already available; and
12
13 Whereas, The private insurers interest in such a database is to use it to replace the
14 FAIRHEALTH database and justify lower payments to physicians; and
15
16 Whereas, Much of the payment data for hospitals is not reliable because hospitals frequently
17 pay employed physicians at a much higher rate than the professional collections; therefore be it
18
19 RESOLVED, That our American Medical Association advocate that any All Payer Database
20 should also provide true payments that hospitals are making to their employed physicians, not
21 just the amount of payment that the insurer is making on the physician's behalf to the hospital.
22 (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

RELEVANT AMA POLICY

Price Transparency D-155.987
1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.
Citation: CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res. 213, I-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed in lieu of: Res. 112, A-19; Modified: Res. 213, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(A-22)

Introduced by: New York, Minority Affairs Consortium

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

Referred to: Reference Committee B

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1 Whereas, The gay or trans panic (to be more inclusive will use “LGBTQ+ panic”) defense
2 strategy is a legal strategy that uses a victim’s sexual orientation or gender identity/expression
3 as an excuse for a defendant’s violent reaction, seeking to legitimize and even to excuse violent
4 and lethal behavior (1); and
5
6 Whereas, The LGBTQ+ “panic” defense strategy gives defendants three options of defense: 1)
7 Defense of insanity or diminished capacity 3) Defense of provocation 3)
8 Defense of self-defense (3); and
9
10 Whereas, To claim insanity, defendants claim that the sexual orientation or gender of the victim
11 is enough to induce insanity (1); and
12
13 Whereas, To claim provocation, defendants claim “victim’s proposition, sometimes termed a
14 “non-violent sexual advance,” was sufficiently “provocative” to induce the defendant to kill the
15 victim”(1); and
16
17 Whereas, To claim self defense, “defendants claim they believed that the victim, because of
18 their sexual orientation or gender identity/expression, was about to cause the defendant serious
19 bodily harm (3)”; and
20
21 Whereas, Studies have shown that jurors with higher in homonegativity and religious
22 fundamentalism ratings assigned higher victim blame, lower defendant responsibility, and more
23 lenient verdicts in the “LGBTQ+ panic” conditions (5,6,7); and
24
25 Whereas, “Gay panic disorder” was removed from the DSM in 1973 because the APA
26 recognized that no such condition exists; and
27
28 Whereas, Many murder sentences have been reduced or defendants have been acquitted
29 using the LGBTQ+ “panic” defense strategy such as in the Matthew Shepard case has been
30 used successfully to mitigate a charge from murder to criminally negligent manslaughter as
31 recently as 2018 (1); and
32
33 Whereas, The LGBTQ community makes up 3.5% of the US population yet, sexual orientation
34 is the motivator of 17% of hate crime attacks with one in four transgender people becoming the
35 victim of a hate crime in their lifetime (4, 5); and
36
37 Whereas, The LGBTQ+ “panic” defense has only been banned in 11 states as of February
38 2021, with legislation having been introduced in 12 more states (1, 2); and

Whereas, At least 57 Transgender or Gender Non-Conforming persons were killed in the US during the year 2021, the highest total since HRC started tracking in 2013, breaking a record from the previous year 2020 (9); and

Whereas, LGBTQ people over 16 years age are: 4 times more likely to become victims of violence compared to non-LGBTQ people; 6 times more likely to experience violence by someone known to them and 2.5 times more likely to be a victim of violence by a stranger; LBT women are 5 times more likely than non-LBT women to experience violent victimization; GBT men face more than twice the risk of violence compared to non-GBT men; and most violent victimization of LGBTQ people is not reported to law enforcement (10, 11); and

Whereas, A legal defense based on panic because of the race, ethnicity or sex of the victims of a violent crimes is not permitted, and similar reasoning must disallow a gay or trans (LGBTQ+) panic defense; therefore be it

RESOLVED, That our American Medical Association seek a federal law banning the use of the so-called “gay or trans (LGBTQ+) panic” defense in homicide, manslaughter, physical or sexual assault cases (Directive to Take Action); and be it further

RESOLVED, That our AMA develop draft legislation, an issue brief and talking points on the topic of so called “gay or trans (LGBTQ+) panic” defense, that can be used by the AMA in seeking federal legislation, and can be used and adapted by state and specialty medical societies, other allies, and stakeholders when seeking state legislation to ban the use of so-called “gay or trans (LGBTQ+) panic” defense to mitigate personal responsibility for violent crimes such as assault, rape, manslaughter, or homicide. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

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RELEVANT AMA POLICY

Preventing Anti-Transgender Violence H-65.957
Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths: (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.
Citation: Res. 008, A-19

Access to Basic Human Services for Transgender Individuals H-65.964
Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with ones gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to ones gender identity.
Citation: Res. 010, A-17

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(A-22)

Introduced by: New York

Subject: Insurance Claims Data

Referred to: Reference Committee B

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1 Whereas, Insurance company claims data is a repository of public health information, utilization
2 information, practice patterns, and other important information; and
3
4 Whereas, The insurers utilize their claims data in order to develop policy, coverage
5 determinations, and pricing; and
6
7 Whereas, The insurers obtain the data from both at risk plans and plans for which they act in the
8 capacity of Third-Party Administrator (TPA); and
9
10 Whereas, Insurers typically do not share this data, asserting that it is proprietary; and
11
12 Whereas, Asymmetry of information is an impediment to more robust health policy, better and
13 more responsive health policy, more cost-effective policy and new entrants into the insurance
14 marketplace; therefore be it
15
16 RESOLVED, That our American Medical Association seek legislation and regulation to promote
17 open sharing of de-identified health insurance claims data. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

RELEVANT AMA POLICY

Work of the Task Force on the Release of Physician Data H-406.990

Release of Claims and Payment Data from Governmental Programs

The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data only when it preserves access to health care and is used to provide accurate physician performance assessments.

Raw claims data used in isolation have significant limitations. The release of such data from government programs must be subject to safeguards to ensure that neither false nor misleading conclusions are derived that could undermine the delivery of appropriate and quality care. If not addressed, the limitations of such data are significant. The foregoing limitations may include, but are not limited to, failure to consider factors that impact care such as specialty, geographic location, patient mix and demographics, plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution.

Raw claims and payment data resulting from government health care programs, including, but not limited to, the Medicare and Medicaid programs should only be released:

1. when appropriate patient privacy is preserved via de-identified data aggregation or if written authorization for release of individually identifiable patient data has been obtained from such patient in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and applicable regulations;
2. upon request of physicians [or their practice entities] to the extent the data involve services that they have provided;
3. to law enforcement and other regulatory agencies when there is reasonable and credible reason to believe that a specific physician [or practice entity] may have violated a law or regulation, and the data is relevant to the agency's investigation or prosecution of a possible violation;
4. to researchers/policy analysts for bona fide research/policy analysis purposes, provided the data do not identify specific physicians [or their practice entities] unless the researcher or policy analyst has (a) made a specific showing as to why the disclosure of specific identities is essential; and, (b) executed a written agreement to maintain the confidentiality of any data identifying specific physicians [or their practice entities];
5. to other entities only if the data do not identify specific physicians [or their practice entities]; or
6. if a law is enacted that permits the government to release raw physician-specific Medicare and/or Medicaid claims data, or allows the use of such data to construct profiles of identified physicians or physician practices. Such disclosures must meet the following criteria:
(a) the publication or release of this information is deemed imperative to safeguard the public welfare;
(b) the raw data regarding physician claims from governmental healthcare programs is:
(i) published in conjunction with appropriate disclosures and/or explanatory statements as to the limitations of the data that raise the potential for specific misinterpretation of such data. These statements should include disclosure or explanation of factors that influence the provision of care including geographic location, specialty, patient mix and demographics, health plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution, in addition to other relevant factors.
(ii) safeguarded to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data.
(c) any physician profiling which draws upon this raw data acknowledges that the data set is not representative of the physicians' entire patient population and uses a methodology that ensures the following:
(i) the data are used to profile physicians based on quality of care provided - never on utilization of resources alone - and the degree to which profiling is based on utilization of resources is clearly identified.
(ii) data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties.
(iii) the data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians.
(d) any governmental healthcare data shall be protected and shared with physicians before it is released or used, to ensure that physicians are provided with an adequate and timely opportunity to review, respond and appeal the accuracy of the raw data (and its attribution to individual physicians) and any physician profiling results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release.
Citation: BOT Rep. 18, A-09; Reaffirmed: BOT Rep. 09, A-19; Modified: Speakers Rep., A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(A-22)

Introduced by: New York

Subject: Insurers and Vertical Integration

Referred to: Reference Committee B

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1 Whereas, Insurers already enjoy significant marketplace advantages, such as keeping
2 healthcare data opaque from other stakeholders, marketplace consolidation, and monopsony
3 power; and
4
5 Whereas, These advantages have not resulted in cost savings (or even stability) for
6 consumers--in fact cost increases born by consumers have been outsized and correlated with
7 consolidation; and
8
9 Whereas, Insurers have increasingly been pursuing mergers--in the name of promoting
10 efficiency; and
11
12 Whereas, These “efficiencies” rarely, if ever, benefit the consumer; and
13
14 Whereas, These combined entities (especially vertical ones) are more competitive among their
15 competitors than the uncombined ones (accelerating further consolidation); and
16
17 Whereas, The combined entities are also positioned (due to their superior access to capital) to
18 unfairly disrupt entities at other points in the supply chain such as medical practices, community
19 pharmacies, and safety net hospitals; therefore be it
20
21 RESOLVED, That our American Medical Association seek legislation and regulation to prevent
22 health payers (except non-profit HMO’s) from owning or operating other entities in the health
23 care supply chain. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

RELEVANT AMA POLICY

Health Insurance Company Purchase by Pharmacy Chains D-160.920
Our AMA will: (1) continue to analyze and identify the ramifications of the proposed CVS/Aetna or other similar merger in health insurance, pharmacy benefit manager (PBM), and retail pharmacy markets and what effects that these ramifications may have on physician practices and on patient care; (2) continue to convene and activate its AMA-state medical association and national medical specialty society coalition to coordinate CVS/Aetna-related advocacy activity; (3) communicate our AMAs concerns via written statements and testimony (if applicable) to the U.S. Department of Justice (DOJ), state attorneys general and departments of insurance; (4) work to secure state level hearings on the merger; and (5) identify and work with national antitrust and other legal and industry experts and allies.
Citation: BOT Action in response to referred for decision Res. 234, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(A-22)

Introduced by: New York

Subject: Medicare Advantage Plan Mandates

Referred to: Reference Committee B

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1 Whereas, Some municipalities are requiring their retirees to change from traditional Medicare
2 health insurance coverage to Medicare Advantage plans; and
3
4 Whereas, Medicare Advantage plans may have restrictive networks; and
5
6 Whereas, Medicare Advantage plans further privatize patients' Medicare, without discussion or
7 agreement by the persons concerned, all in the interest of saving money for the employer; and
8
9 Whereas, Forcing use of Medicare Advantage plans does not consider the retiree's personal
10 health concerns, including the ability to find continued care with their own doctors or hospitals
11 with whom they may have long relationships; therefore be it
12
13 RESOLVED, That our American Medical Association advocate for federal legislation to ensure
14 that no person should be mandated to change from traditional Medicare to Medicare Advantage
15 plans. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

RELEVANT AMA POLICY

Ending Medicare Advantage Auto-Enrollment H-285.905
Our AMA will work with the Centers for Medicare and Medicaid Services and/or Congress to end the procedure of "auto-enrollment" of individuals into Medicare Advantage Plans.
Citation: Res. 216, I-16

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930
Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.
Citation: BOT Action in response to referred for decision Res. 711, I-06; Reaffirmation A-08; Modified: CMS Rep. 01, A-19

Elimination of Subsidies to Medicare Advantage Plans D-390.967
1. Our AMA will seek to have all subsidies to private plans offering alternative coverage to Medicare beneficiaries eliminated, that these private Medicare plans compete with traditional

Medicare fee-for-service plans on a financially neutral basis and have accountability to the Centers for Medicare and Medicaid Services.
2. Our AMA will seek to prohibit all private plans offering coverage to Medicare beneficiaries from deeming any physician to be a participating physician without a signed contract specific to that product, and that our AMA work with CMS to prohibit all-products clauses from applying to Medicare Advantage plans and private fee-for-service plans.
Citation: Res. 229, A-07; Modified: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(A-22)

Introduced by: New York

Subject: Physician Tax Fairness

Referred to: Reference Committee B

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1 Whereas, In 2018, President Trump signed the Tax Cuts and Jobs Act; and
2
3 Whereas, This legislation includes a tax break for owners of certain pass-through entities, many
4 of which include physician practices structured as such and can include S corporations,
5 partnerships and some limited liability companies; and
6
7 Whereas, This may benefit those who earn below the threshold of $207,500 or less for a single
8 filer (where the deduction phases out when taxable income exceeds $157,500) or $415,000 or
9 less for a married couple filing jointly (where the deduction phases out starting at $315,000); and
10
11 Whereas, The new tax law disallows this 20% deduction for taxpayers with income above the
12 threshold in specified service businesses which are defined as those in which the principal asset
13 is the reputation or skill of the owners and which category includes physicians; and
14
15 Whereas, Many physicians, especially those in two physician households, will not qualify under
16 the new tax law, and combined with the decrease in the deductions allowed for state and local
17 taxes, home mortgage, etc., many physicians have been adversely affected and will pay more in
18 taxes; and
19
20 Whereas, The effect of this law will be a continued trend of decreased physician self-
21 employment and thus overall lower physician reimbursement; therefore be it
22
23 RESOLVED, That our American Medical Association lobby that physicians be excluded from
24 being considered a specified service business as defined by the Internal Revenue Service.
25 (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(A-22)

Introduced by: New York

Subject: Prohibit Ghost Guns

Referred to: Reference Committee B

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

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

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

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

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

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

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

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

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

RESOLVED, That our American Medical Association support state and federal legislation and regulation that would subject homemade weapons to the same regulations and licensing requirements as traditional weapons. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 03/22/22

RELEVANT AMA POLICY

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.
Therefore, the AMA:
(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.
Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19

Firearm Availability H-145.996
1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.
Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

Ban on Handguns and Automatic Repeating Weapons H-145.985
It is the policy of the AMA to:
(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;
(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
(d) the imposition of significant licensing fees for firearms dealers;
(e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
(f) mandatory destruction of any weapons obtained in local buy-back programs.
(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
(4) Oppose concealed carry reciprocity federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.
(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.
Citation: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14; Appended: Res. 427, A-18; Reaffirmation: A-18; Modified: Res. 244, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(A-22)

Introduced by: Medical Student Section

Subject: Supporting Collection of Data on Medical Repatriation

Referred to: Reference Committee B

Whereas, Forced medical repatriation is the involuntary return of civilians in need of medical treatment to their country of origin by healthcare professionals[1]; and

Whereas, Forced medical repatriation results in an involuntary transfer of a patient to a foreign country, provoking an unwarranted intersection between immigration enforcement and the healthcare system[2]; and

Whereas, Of the estimated 10.5 million undocumented immigrants in the United States in 2017, a study found expenditures on immigrants in 2016 accounted for less than 10% of the overall healthcare spending in a population with the highest risk of being uninsured among the non-elderly population[2-4]; and

Whereas, Under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), federally funded health institutions with emergency care capabilities are mandated to treat all patients with emergent medical conditions who present to their facility until deemed stable, regardless of their insurance coverage or financial status[5]; and

Whereas, Once deemed stable, medical centers must consider medical repatriation if no long-term care alternative is available to the patient as a cost-saving mechanism[6]; and

Whereas, Care centers like St. Joseph's Hospital and Medical Center in Phoenix, Arizona, partake in forced medical repatriation for undocumented immigrant patients and a Florida patient experienced involuntary deportation prior to the completion of their appeal or asylum verdict[7-9]; and

Whereas, Forced medical repatriation has led to serious medical consequences for patients, including the exacerbation of existing medical conditions[10,11]; and

Whereas, Patients experienced a lapse and deterioration of care due to the inability of the patient's country of origin to provide adequate treatment and concurrent separation from their community in the U.S. during a time which may require emotional, physical and financial support[6,7,9,12]; and

Whereas, Hospitals fail to inform patients, or their guardians of potential adverse medical consequences related to repatriation[7,13]; and

Whereas, Forced medical repatriation increases health disparities among migrant communities and deters immigrants from seeking necessary medical services[14,15];and

Whereas, Forced medical repatriation often violates the Centers for Medicare and Medicaid Services' Conditions of Participation regulation which commits hospitals to ensure patients have the right to conduct informed decisions regarding their care[16,17]; and

Whereas, Forced medical repatriation violates the patient's constitutional right to due process, especially if the patient is able to claim asylum[18]; and

Whereas, The *AMA Journal of Ethics* encourages health care systems to seek routes of care to avoid forced medical repatriation and the *AMA Code of Ethics* Opinion 1.1.8 states that "physicians should resist any discharge requests that are likely to compromise a patient's safety" and that the "discharge plan should be developed without regard to socioeconomic status, immigration status, or other clinically irrelevant considerations" [2,19,20]; and

Whereas, The AMA is pursuing policy focused on alternative routes for immigrant healthcare through Health Care Payment for Undocumented Persons (D-440.985) and Federal Funding for Safety Net Care for Undocumented Aliens (H-160.956)[21,22]; and

Whereas, Data on repatriation of civilians is not reported through any government agency or otherwise, and there is a lack of documentation[7,23]; therefore be it

RESOLVED, That our American Medical Association ask the Department of Health and Human Services to collect and de-identify any and all instances of medical repatriations from the United States to other countries by medical centers to further identify the harms of this practice (Directive to Take Action); and be it further

RESOLVED, That our AMA denounce the practice of forced medical repatriation. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000

Date Received: 04/08/22

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RELEVANT AMA POLICY

EMTALA -- Major Regulatory and Legislative Developments D-130.982

Our AMA: (1) continue to work diligently to clarify and streamline the EMTALA requirements to which physicians are subject; (2) continue to work diligently with the Department of Health and Human Services (HHS) to further limit the scope of EMTALA, address the underlying problems of emergency care, and provide appropriate compensation and adequate funding for physicians providing EMTALA-mandated services; (3) communicate to physicians its understanding that following inpatient admission of a patient initially evaluated in an emergency department and stabilized, care will not be governed by the EMTALA regulations; and (4) continue strongly advocating to the Federal government that, following inpatient admission of a patient evaluated in an emergency department, where a patient is not yet stable, EMTALA regulations shall not apply.
BOT Rep. 17, I-02, Reaffirmation: A-07, Modified: BOT Rep. 22, A-17

Access to Emergency Services H-130.970

1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:
(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.
(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)
(C) All health plans should be prohibited from requiring prior authorization for emergency services.
(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.
(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third-party payer whether it is retrospectively determined that an emergency existed or not.
(G) States should be encouraged to enact legislation holding health plans and third-party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.
(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.
(I) In instances in which no private or public third-party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.
2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the "prudent layperson" standard of determining when to seek emergency care.
CMS Rep. A, A-89, Modified: CMS Rep. 6, I-95, Reaffirmation: A-97, Reaffirmed: Sub. Res. 707, A-98, Reaffirmed: Res. 705, A-99, Reaffirmed: CMS Rep. 3, I-99, Reaffirmation: A-00, Reaffirmed: Sub. Res. 706, I-00, Amended: Res. 229, A-01, Reaffirmation and Reaffirmed: Res. 708, A-02, Reaffirmed: CMS Rep. 4, A-12, Reaffirmed: CMS Rep. 07, A-16, Appended: Res. 128, A-17, Reaffirmation: A-18, Reaffirmed in lieu of: Res. 807, I-18

Emergency Medical Treatment and Active Labor Act (EMTALA) H-130.950
Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act ((EMTALA)) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under (EMTALA); (2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act ((EMTALA)) rules and regulations; (3) urgently seeks return to the original congressional intent of (EMTALA) to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and (4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous (EMTALA) requirements.
Sub. Res. 214, A-97, Reaffirmation: I-98, Reaffirmation: A-99, Appended: Sub. Res. 235 and Reaffirmation A-00, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17)

Emergency Transfer Responsibilities H-130.957
Our AMA supports seeking amendments to Section 1867 of the Social Security Act, pertaining to patient transfer, to:
(1) require that the Office of the Inspector General (IG) request and receive the review of the Quality Improvement Organization (QIO) prior to imposing sanctions;
(2) make the QIO determination in alleged patient transfer violations binding upon the IG;
(3) expand the scope of QIO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks;
(4) restore the knowing standard of proof for physician violation;
(5) recognize appropriate referral of patients from emergency departments to physician offices;
(6) clarify ambiguous terms such as emergency medical transfer and stabilized transfer;
(7) clarify ambiguous provisions regarding the extent of services which must be provided in examining/treating a patient;
(8) clarify the appropriate role of the on-call specialist, including situations where the on-call specialist may be treating other patients; and
(9) clarify that a discharge from an emergency department is not a transfer within the meaning of the act.

Sub. Res. 78, A-91, Reaffirmation: A-00, Reaffirmed: BOT Rep. 6, A-10; Modified: BOT Rep. 04, A-20

Repeal of COBRA Anti-Physician Provisions H-130.959
It is the policy of the AMA (1) to seek legal or legislative opportunities to clarify that Section 1867 of the Social Security Act applies only to inappropriate transfers from hospital emergency departments and not to issues of malpractice; and (2) to continue to seek appropriate modifications of Section 1867 of the Social Security Act to preclude liability for discharges from the hospital, including emergency department and outpatient facility.
Sub. Res. 145, I-90, Reaffirmed: Sunset Report, I-00, Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 04, A-20

Health Care Payment for Undocumented Persons D-440.985
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.
Res. 148, A-02, Reaffirmation: A-07, Reaffirmed: CMS Rep. 1, A-17, Reaffirmation: A-19; Reaffirmation: I-19

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.
Res. 920, I-06, Reaffirmed and Appended: Res. 140, A-07, Modified: CCB/CLRPD, Rep. 2, A-14

Federal Funding for Safety Net Care for Undocumented Aliens H-160.956
Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens.
Sub. Res. 207, A-93, Reaffirmed: BOT Rep. 17, I-94, Reaffirmed: Ref Com B, A-96, Reaffirmation: A-02, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17, Reaffirmation: A-19; Reaffirmation: I-19

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921
Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.
Res. 232, I-17)

Addressing Immigrant Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of refugees and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

Res. 804, I-09, Appended: Res. 409, A-15, Reaffirmation: A-19, Appended: Res. 423, A-19; Reaffirmation: I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(A-22)

Introduced by: Medical Student Section

Subject: Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits

Referred to: Reference Committee B

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1 Whereas, Rape and/or sexual assault is common in the United States, with between 135,755
2 and 393,980 rapes and/or sexual assaults committed in 2017 alone[1,2]; and
3
4 Whereas, 43.6% of women and 24.8% of men have experienced some form of sexual violence,
5 including unwanted sexual contact of any kind, in their lifetimes[3]; and
6
7 Whereas, Rape and sexual assault are associated with a wide range of medical and
8 psychological sequelae, including direct physical trauma, PTSD, depression, social phobias,
9 mood regulation deficiencies, impaired sexual function, anxiety, self-harm, suicidal ideation and
10 suicide attempts[4-14]; and
11
12 Whereas, Data suggests that a significant proportion of rapes and/or sexual assaults are
13 committed by serial offenders[15-19]; and
14
15 Whereas, Identification and incarceration of perpetrators of violent sexual crimes reduces the
16 incidence of future sexual violence committed by these serial offenders[17-23]; and
17
18 Whereas, Sexual assault evidence kits (SAEKs), which refer to kits used to collect and store
19 evidence from a victim of sexual assault during a sexual assault forensic examination, are
20 extremely useful in the identification and prosecution of perpetrators of violent sexual crime and
21 are positively associated with successful prosecutions[17,19,22,23-27]; and
22
23 Whereas, Even when suspects cannot be immediately identified on the basis of the DNA
24 signature derived from a SAEK, law enforcement officials can upload the DNA profile to the
25 Federal Bureau of Investigation's Combined DNA Index System (CODIS), which can assist in
26 the later identification of the perpetrator[28]; and
27
28 Whereas, Despite the obvious utility of testing SAEKs, many remain untested and stored in law
29 enforcement evidence warehouses ("backlogged"), with estimates placing the number of
30 backlogged kits as high as 200,000 nationwide[19,29]; and
31
32 Whereas, The cause of backlogged SAEKs have been attributed to lack of standardized policies
33 and procedures, including federal guidelines, inadequate training of law enforcement officers,
34 outdated laboratory policies and lack of resources, such as funding[30]; and
35
36 Whereas, The United States Department of Justice's Violence Against Women Act of 1994
37 (VAWA) and its subsequent reauthorizations provides grants to programs offering medical
38 services to sexual assault survivors contingent on those programs incurring the full cost of
39 forensic medical exams through the offices of State Attorney's General[31-33]; and

Whereas, Standardized insurance billing procedures that include copays and other cost-sharing payments cause victims of sexual assault to be billed for part of the cost of testing forensic evidence, notwithstanding federal mandates like VAWA[34,35]; and

Whereas, The Bureau of Justice Assistance in the US Department of Justice administers the Sexual Assault Kit Initiative (SAKI), a grant program that assists police departments in testing backlogged SAEKs, has resulted in the disbursement of $43 million and the testing of 50,500 kits[40-42]; and

Whereas, Counties that have voluntarily worked to test all backlogged SAEKs in their possession have been extraordinarily successful in solving previously unsolved rapes and sexual assaults[17,19,21,22,36-40]; and

Whereas, Many of these SAEKs, if tested earlier, would have led to the identification and incarceration of serial offenders that would have prevented later assaults[17,19-22,36-38]; and

Whereas, The $9.6 million SAEK testing initiative in Cuyahoga County, Ohio financed new forensic examinations in addition to comprehensive coverage of investigations on backlogged kits with a net estimated savings of $38.7 million, highlighting the cost effectiveness of testing SAEKs[41,42]; and

Whereas, Existing AMA Policy H-80.999 outlines the rights of sexual assault victims but neither explicitly describes the right to have collected medical forensic evidence be tested in a timely manner nor addresses the backlog of untested sexual assault evidence kits; therefore be it

RESOLVED, That our American Medical Association amend Policy H-80.999, "Sexual Assault Survivors," by addition to read as follows:

H-80.999 – SEXUAL ASSAULT SURVIVORS

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitations (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
5. <u>Our AMA will advocate at the state and federal level for (a) the immediate processing of all "backlogged" and new sexual assault examination kits; and (b) additional funding to facilitate the immediate testing of sexual assault evidence kits.</u> (Modify Current HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000

Date Received: 04/08/22

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RELEVANT AMA POLICY

Sexual Assault Survivors H-80.999
1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: Res. 202, I-17; Appended: Res. 902, I-18

Sexual Assault Survivor Services H-80.998
Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.
Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17

Addressing Sexual Assault on College Campuses H-515.956
Our AMA: (1) supports universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting; (2) will work with relevant stakeholders to address the issues of rape, sexual abuse, and physical abuse on college campuses; and (2) will strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses.
Res. 402, A-16; Appended: Res. 424, A-18

HIV, Sexual Assault and Violence H-20.900
Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained; and (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, and (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use.
CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Res. 905, I-18

Access to Emergency Contraception H-75.985
It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter.
CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04; Reaffirmed: CSAPH Rep. 1, A-14

Insurance Discrimination Against Victims of Domestic Violence H-185.976
Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence.
Res. 814, I-94; Appended: Res. 419, I-00; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19

AMA Code of Medical Ethics 8.10 Preventing, Identifying and Treating Violence and Abuse
All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse.
To protect patients' well-being, physicians individually should:
(a) Become familiar with:
(i) how to detect violence or abuse, including cultural variations in response to abuse;
(ii) community and health resources available to abused or vulnerable persons;
(iii) public health measures that are effective in preventing violence and abuse;
(iv) legal requirements for reporting violence or abuse.
(b) Consider abuse as a possible factor in the presentation of medical complaints.
(c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.
(d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in "normal" families, is a private matter best resolved without outside interference, or is caused by victims' own actions.
(e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.
(f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.
(g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should:
(i) inform patients about requirements to report;

(ii) obtain the patient's informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.
(h) Protect patient privacy when reporting by disclosing only the minimum necessary information.
Collectively, physicians should:
(i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.
(j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.
(k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.
(l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.
(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(A-22)

Introduced by: American Academy of Neurology, American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology-Head and Neck Surgery, American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons, American College of Cardiology, American College of Emergency Physicians, American College of Physicians, American College of Surgeons, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy, American Society for Surgery of the Hand, American Society of Echocardiography, American Society of Nuclear Cardiology, American Urological Association, California, Congress of Neurological Surgeons, North American Spine Society, Society for Cardiovascular Angiography & Interventions, Society of Cardiovascular Computed Tomography, Washington

Subject: Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program

Referred to: Reference Committee B

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1 Whereas, In 2014, Congress passed the Protecting Access to Medicare Act (PAMA) [Public
2 Law 113-93], establishing the Medicare Appropriate Use Criteria (AUC) Program for advanced
3 diagnostic imaging; and
4
5 Whereas, Eight years after PAMA's enactment, the Centers for Medicare & Medicaid Services
6 (CMS) continues to face challenges in completing the rulemaking and implementation of the
7 AUC program, fueling existing concerns about the complexity of the law, associated costs, and
8 regulatory burden sustained by physicians and other health care providers to meet the program
9 requirements; and
10
11 Whereas, The AUC program, if ever fully implemented, would impact a substantial number of
12 clinicians, as it would apply to every clinician who orders or furnishes an advanced diagnostic
13 imaging test, unless a statutory or hardship exemption applies; and
14
15 Whereas, Practitioners whose ordering patterns are considered outliers will be subject to prior
16 authorization--at a time when physicians are working to advance policies that reduce the
17 administrative burdens associated with prior authorization; and
18
19 Whereas, The program will be a financial burden for many practices, as it is estimated to cost
20 $75,000 or more for a practice to implement a Clinical Decision Support Mechanism (CDSM)
21 that complies with the AUC Program rules[1]; and
22
23 Whereas, The law is prescriptive, requiring clinicians to use only CDSMs qualified by CMS and
24 only AUC developed by certain qualified entities--preventing the use of other clinical decision
25 support tools and evidenced-based guidelines for advanced diagnostic imaging developed by
26 medical societies and other health care institutions; and

[1] Association for Medical Imaging Management; 2017 https://ahralink.files.wordpress.com/2017/03/cds-survey- 2017.pdf

Whereas, The AUC program creates a complex exchange of information between clinicians that is not yet supported by interoperable electronic health record systems and relies on claims-based reporting at a time when CMS is migrating from claims reporting for quality data; and

Whereas, Since PAMA's enactment, the AUC program has become obsolete given the subsequent enactment of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 and the rise of new health care payment and delivery models via the Quality Payment Program (QPP) (alternative payment models and Merit-based Incentive Payment System) designed to hold clinicians responsible for health care resource use; and

Whereas, Five years after the program's intended start date, technical challenges, including the need for claims processing edits to prevent claim denials, have further eroded physician confidence in and support for the program; and

Whereas, Awareness of the program among physicians and other health care professionals remains low, which is supported by CMS' estimate--based on CY2020 Medicare claims during the program's education and operations testing phase--that between 9-10 percent of all claims subject to the AUC program reported information sufficient to be considered compliant with the program; and

Whereas, In the CY 2022 Medicare Physician Fee Schedule final rule, CMS finalized its proposal to begin the payment penalty phase of the AUC program until the later of January 1, 2023, or the January 1 of the year following the end of the COVID-19 public health emergency; and

Whereas, Congress and CMS must seriously consider the degree to which the AUC program and QPP requirements overlap and create duplicative reporting burdens for physicians already overwhelmed by the variety of other administrative burdens associated with care delivery; and

Whereas, There is widespread agreement in the medical community that the program cannot be implemented as originally envisioned without imposing undue burden and cost on physician practices; therefore be it

RESOLVED, That our American Medical Association Policy H-320.940, "Medicare's Appropriate Use Criteria Program," be amended by addition and deletion to read as follows:

> Our AMA will ~~continue to~~ advocate to Congress for ~~delay the effective date~~ either the full repeal of the Medicare Appropriate Use Criteria (AUC) Program or legislative modifications to the program in such a manner that ~~until the Centers for Medicare & Medicaid Services (CMS) can~~ adequately addresses technical and workflow challenges, ~~with its implementation and any interaction between~~ maximizes alignment with the Quality Payment Program (QPP), and ~~the use of advanced diagnostic imaging appropriate use criteria.~~ creates provider flexibility for the consultation of AUC or advanced diagnostic imaging guidelines using a mechanism best suited for their practice, specialty and workflow. (Modify Current HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

RELEVANT AMA POLICY

Medicare's Appropriate Use Criteria Program H-320.940
Our AMA will continue to advocate to delay the effective date of the Medicare Appropriate Use Criteria (AUC) Program until the Centers for Medicare & Medicaid Services (CMS) can adequately address technical and workflow challenges with its implementation and any interaction between the Quality Payment Program (QPP) and the use of advanced diagnostic imaging appropriate use criteria.
Citation: Res. 229, A-17; Reaffirmed - BOT Action in response to referred for decision: Res. 245, A-19 and Res. 247, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(A-22)

Introduced by: Michigan

Subject: Medication for Opioid Use Disorder in Physician Health Programs

Referred to: Reference Committee B

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1 Whereas, Physician Health Programs (PHPs) are designed to allow physicians with potentially
2 impairing conditions who either come forward or are referred to be given the opportunity for
3 evaluation, rehabilitation, treatment, and monitoring without disciplinary action in an anonymous,
4 confidential, and respectful manner; and
5
6 Whereas, The PHP model is intended to ensure participants receive effective clinical care for
7 mental, physical, and substance abuse disorders and access to a variety of clinical interventions
8 and support; and
9
10 Whereas, Currently, physicians referred to PHPs who are diagnosed with opioid use disorder
11 (OUD) involving monitoring or sanctions may be subjected to punitive action by their respective
12 licensing boards; and
13
14 Whereas, The stigma associated with illness and impairment, particularly impairment resulting
15 from mental illness, including substance use disorders, can be a powerful obstacle to seeking
16 treatment, especially in the medical community where the presence of this stigma has been
17 described in the literature; and
18
19 Whereas, The US Food and Drug Administration recommends approved medications for the
20 treatment of opioid use disorder (MOUD) including methadone, buprenorphine, and naltrexone
21 be available to all patients; and
22
23 Whereas, MOUD has been proven to help maintain recovery and prevent death in patients with
24 opioid use disorder (OUD); and
25
26 Whereas, It is reported that patients who use MOUD remain in therapy longer than those who
27 do not, and are less likely to use illicit opioids; and
28
29 Whereas, A 2019 report from the National Academies of Sciences, Engineering, and Medicine
30 stated that “there is no scientific evidence that justifies withholding medications from OUD
31 patients in any setting” and that such practices amount to “denying appropriate medical
32 treatment,” and that such practices amount to “denying appropriate medical treatment”; and
33
34 Whereas, Clinicians should consider a patient’s preferences, past treatment history, current
35 state of illness, and treatment setting when deciding between the use of methadone,
36 buprenorphine, and naltrexone; and
37
38 Whereas, Additional considerations apply to health professionals who are actively engaged in,
39 or planning to return to, safety sensitive work; and

Whereas, Treatment programs offering the best possible outcomes are critical to ensuring a pathway to recovery and continuation of clinical practice in a safe and ethical manner with patient protection at the forefront; and

Whereas, The American Society of Addiction Medicine's *Public Policy Statement on Physicians and other Healthcare Professionals with Addiction* includes the recommendation that "Healthcare professionals should be offered the full range of evidence-based treatments, including medication for addiction, in whatever setting they receive treatment. Regulatory agencies (including state licensing boards), professional liability insurers, and credentialing bodies should not discriminate against the type of treatment an individual receives based on unjustified assumptions that certain treatments cause impairment;" therefore be it

RESOLVED, That our American Medical Association reaffirm policy H-95.913, "Discrimination Against Physicians in Treatment with Medication for Opioid Use Disorders" (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA modify policy D-405.990, "Educating Physicians About Physician Health Programs and Advocating for Standards," by addition to read as follows:

> Our AMA will:
> (1) work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory;
> (2) continue to collaborate with relevant organizations on activities that address physician health and wellness;
> (3) in conjunction with the FSPHP, develop <u>model</u> state <u>legislation and/or</u> legislative guidelines addressing the design and implementation of physician health programs <u>including, but not limited to, the allowance for safe-haven or non-reporting of physicians to a licensing board, and/or acceptance of Physician Health Program compliance as an alternative to disciplinary action when public safety is not at risk, and especially for any physicians who voluntarily self-report their physical, mental, and substance use disorders and engage with a Physician Health Program and who successfully complete the terms of participation</u>;
> (4) work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training;
> (5) continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; and
> (6) continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options. (Modify Current HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

RELEVANT AMA POLICY

Discrimination Against Physicians in Treatment with Medication for Opioid Use Disorders (MOUD) H-95.913
1. Our AMA affirms: (a) that no physician or medical student should be presumed to be impaired by substance or illness solely because they are diagnosed with a substance use disorder; and (b) that no physician or medical student should be presumed impaired because they and their treating physician have chosen medication for opioid use disorder (MOUD) to address the substance use disorder, including but not limited to methadone and buprenorphine.
2. Our AMA strongly encourages the leadership of physician health and wellness programs, state medical boards, hospital and health system credentialing bodies, and employers to help end stigma and discrimination against physicians and medical students with substance use disorders and allow and encourage the usage of medication for opioid use disorder (MOUD), including but not limited to methadone or buprenorphine, when clinically appropriate and as determined by the physician or medical student (as patient) and their treating physician, without penalty (such as restriction of privileges, licensure, ability to prescribe medications or other treatments, or other limits on their ability to practice medicine), solely because the physician's or medical student's treatment plan includes MOUD.
3. Our AMA will survey physician health programs and state medical boards and report back about the prevalence of MOUD among physicians under monitoring for OUD, types of MAT utilized, and practice limitations or other punitive measures, if any, imposed solely on the basis of medication choice.
Citation: Res. 001, A-21

Educating Physicians About Physician Health Programs and Advocating for Standards D-405.990
Our AMA will:
(1) work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory;
(2) continue to collaborate with relevant organizations on activities that address physician health and wellness;
(3) in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs;
(4) work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training;
(5) continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; and
(6) continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options.

Citation: Res. 402, A-09; Modified: CSAPH Rep. 2, A-11; Reaffirmed in lieu of Res. 412, A-12; Appended: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed: BOT Rep. 15, A-19; Modified: Res. 321, A-19

Physician Impairment H-95.955
(1) The AMA defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program.
(2) The AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of illnesses with the potential to cause impairment that affect physicians, to develop case finding mechanisms for all types of physician impairments, and to collect data on the prevalence of conditions affecting physician health.
(3) The AMA encourages additional research in the area of physician illness with the potential to cause impairment, particularly in the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems.
Citation: CSA Rep. 1, A-95; Reaffirmed: BOT Rep. 17, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: BOT Rep. 15, A-19; Modified: CSAPH Rep. 01, A-19

Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder D-95.968
1. Our AMA will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.
2. Our AMA supports further research into how primary care practices can implement medication-assisted treatment (MAT) into their practices and disseminate such research in coordination with primary care specialties.
3. The AMA Opioid Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.
Citation: Res. 222, A-18; Appended: BOT Rep. 02, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(A-22)

Introduced by: Michigan

Subject: Resentencing for Individuals Convicted of Marijuana-Based Offenses

Referred to: Reference Committee B

Whereas, Incarceration is a key issue under the domain of Social and Community Context in the Social Determinants of Health topic area of Healthy People 2020 due to numerous disparities in inmate mental and physical health compared to the population, as well as the increased rate of mental health disorders in the children of incarcerated parents; and

Whereas, There is a clear link between incarceration and health, with incarcerated individuals showing higher risk of chronic conditions such as cardiovascular disease, hypertension, and cancer compared to the general population; a study in March 2013 found that each additional year an individual spends in prison corresponds with a decline in life expectancy by two years; and

Whereas, Incarcerated populations are particularly vulnerable to the coronavirus disease 2019 (COVID-19) given the demographics of those experiencing incarceration in addition to the inability to properly "social distance", high population turnover, unsanitary living conditions, poor ventilation systems, inability or inadequacy to properly test and track COVID-19 cases and exposure which have led to an estimated 113,664 COVID-19 cases and 887 related deaths among incarcerated people as of August 2020; and

Whereas, Arrests for marijuana possession, regardless of whether the person was later convicted on these charges, have been shown to negatively impact opportunities such as finding employment, housing, and obtaining student loans, which can lead to widespread and multifactorial individual health consequences; furthermore, criminalization of drug use is associated with increased stigma and discrimination of drug users and that stigma and discrimination is also a causal factor for decreased mental and physical health; and

Whereas, Nationally, African Americans are three times more likely to be arrested for marijuana possession than Whites, a finding that cannot be explained by differences in use; and

Whereas, A 2014 report by the National Research Council found that mandatory minimum sentences for drug offenders “have few, if any, deterrent effects;” and

Whereas, Eighteen states, two territories, and the District of Columbia have legalized the use of recreational and medicinal marijuana, and in the past four years, 23 states have passed laws addressing expungement of certain marijuana convictions, pairing these laws with other policies to its decriminalization or legalization; and

Whereas, In 2018, California became the first state to enact legislation ordering its Department of Justice to conduct a review of criminal records and identify past convictions eligible for sentence dismissal or re-designation in accordance with the Adult Use of Marijuana Act; the outcomes of this legislation showed that reductions in criminal penalties for drug possession

reduce racial and ethnic disparities in the criminal justice system, allowing for improvements in health inequalities linked to social determinants of health; and

Whereas, Illinois passed a bill in May 2019, to expunge convictions for non-violent crimes of possession, manufacturing, and distribution of up to 30 grams and possession up to 500 grams, and Colorado and Massachusetts have approved legislation allowing individuals convicted for possession to petition to seal criminal records of misdemeanor offenses that are no longer considered crimes; and

Whereas, A recent study examining the impact of this type of expungement found that those who do obtain expungement have extremely low subsequent crime rates and experience a significant increase in their wage and employment trajectories and an overall positive impact on the lives of those affected; however, of those legally eligible for expungement, only 6.5 percent obtain it within five years of eligibility, findings that support the development of “automatic” expungement procedures; and

Whereas, Those who have received resentencing for past offenses, including decriminalized marijuana-based charges, have experienced an increase of 22 percent in wages on average within one year of resentencing as well as lower subsequent crime rates that compare favorably to the general population; and

Whereas, Our AMA has policy (H-95.924) supporting public health-based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal us and encouraging research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; and

Whereas, Legislation has been considered at the federal level to, among other provisions, remove marijuana from the list of controlled substances under the Controlled Substances Act and create an opportunity for individuals with marijuana law convictions to petition for expungement and resentencing; therefore be it

RESOLVED, That our American Medical Association adopt policy supporting the expungement, destruction, or sealing of criminal records for marijuana offenses that would now be considered legal (New HOD Policy); and be it further

RESOLVED, That our AMA adopt policy supporting the elimination of violations or other penalties for persons under parole, probation, pre-trial, or other state or local criminal supervision for a marijuana offense that would now be considered legal. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

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RELEVANT AMA POLICY

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924
Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.
Citation: CSAPH Rep. 05, I-17; Appended: Res. 913, I-19; Modified: CSAPH Rep. 4, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(A-22)

Introduced by: Ohio

Subject: Eliminating Unfunded or Unproven Mandates and Regulations

Referred to: Reference Committee B

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1 Whereas, Beginning in 2020, Centers for Medicare and Medicaid Services (CMS) will be
2 demanding that “providers” utilize approved “technology” using practice guidelines when
3 ordering imaging studies; and
4
5 Whereas, Such guidelines represent an unfunded mandate for physicians already struggling
6 with massive governmental regulatory burden and underpayment; and
7
8 Whereas, These technologies or “Augmented Intelligence,” are limited in their ability to apply
9 clinical context, thus limiting a physician’s ability to order appropriate testing under unique
10 circumstances and stagnating their work-flow, placing patients at risk; and
11
12 Whereas, The technology required for this mandatory decision support is extremely expensive,
13 especially for smaller and independent physician practices; therefore be it
14
15 RESOLVED, That our American Medical Association advocate for policies that allow for
16 physician judgment and documented medical decision-making to supersede government
17 regulation--including the utilization of Augmented Intelligence--in instances of disputes in patient
18 care (Directive to Take Action); and be it further
19
20 RESOLVED, That our AMA advocate for policies that require “proof of concept,” in the form of
21 independently demonstrated quality improvement, prior to the implementation of any
22 government, insurance company or other third party mandate or regulation on patient care and
23 the physician-patient relationship (Directive to Take Action); and be it further
24
25 RESOLVED, That our AMA advocate for policies requiring government, insurance company or
26 other third party entities to fully fund any mandates or regulations imposed on patient care and
27 the physician-patient relationship. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(A-22)

Introduced by: American College of Cardiology, American Society of Echocardiography, American Society of Nuclear Cardiology, Heart Rhythm Society, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography

Subject: Transforming Professional Licensure to the 21st Century

Referred to: Reference Committee B

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1 Whereas, The US Supreme Court in 1889 affirmed the power of individual states to regulate
2 medical practice within their borders, in conjunction with the exercise of appropriate professional
3 responsibility by local medical societies and all practicing physicians, to protect the public health
4 and safety; and
5
6 Whereas, The Flexner Report of 1911 transformed the nature and process of medical education
7 in America to a comprehensive national standard, with national medical board examinations,
8 nationally accredited residency programs and national certifications from medical specialty
9 boards; and
10
11 Whereas, Individual state medical boards, having verified an applicant's standardized general
12 medical training, professional character and compliance with local state regulations, issue broad
13 general medical licenses which are not specialty specific nor tailored to anticipated need for
14 direct physical interaction or face-to-face contact between the patient and the professional being
15 licensed; and
16
17 Whereas, Individual state medical boards also evaluate a licensed physician's ongoing
18 professional conduct, reviewing complaints from patients, malpractice data, information from
19 hospitals and other health care institution and reports from government agencies, imposing
20 discipline as necessary to protect the public; and
21
22 Whereas, Congress established the National Practitioner Data Bank in 1986 as a nationwide
23 repository for reports containing information on medical malpractice payments and certain
24 adverse actions related to health care practitioners, providers, and suppliers in order to improve
25 health care quality, protect the public and reduce health care fraud and abuse, preventing
26 practitioners from moving state to state without disclosure or discovery of previous damaging
27 performance; and
28
29 Whereas, The Federation of State Medical Boards, the Federation Credential Verification
30 Service, the National Board of Medical Examiners, the Interstate Medical Licensing Compact
31 and other national organizations serve to streamline and facilitate collaboration among the 70
32 independent state-based medical boards authorized to regulate medical practice within their
33 borders; and
34
35 Whereas, Current state licensing procedures, while constantly improving, fail to promote
36 efficient use of modern telecommunication and delivery of a broad range of health care services
37 across state lines, are unnecessarily complex, nonuniform, redundant, expensive, time

consuming, and poorly focused on actual patient care, resulting in the inhibition of free flow of professional expertise and services across state lines; and

Whereas, Telemedicine has developed rapidly over the last decades into an integrated system of healthcare delivery that incorporates many different remote diagnostic and monitoring devices and other technologies that are not dependent on in-person or face-to-face patient encounters; and

Whereas, Incentives to reduce the high cost of medical care have led to shorter hospital stays, increased use of outpatient facilities and home care with less intense in-person physician supervision, and more frequent collaborative care delivered by non-physician professionals; and

Whereas, Telemedicine has been proven effective in many scenarios, in remote or rural settings, urban areas with limited public transportation, in nursing homes, detention centers, prisons, and for people with physical and mental disabilities limiting their mobility; and

Whereas, The use of telemedicine has grown exponentially during the COVID pandemic to protect both patients and caregivers from spread of infectious disease; and

Whereas, Telemedicine may be especially helpful in addressing disparities in access to medical care based on economic, racial, ethnic, and geographic factors; and

Whereas, There is a worsening shortage of physicians particularly in rural or urban communities that lack comprehensive, supportive, up-to-date medical services and cultural, educational, and recreational amenities outside the workplace; and

Whereas, Current AMA policy H-480.969 requires full and unrestricted licensure in the state of residence where telemedicine is practiced, where the patient is physically located, with certain exceptions; and

Whereas, Current AMA policy H-160.950 requires a physician to be responsible for managing the health care of patients in all practice settings, including medication prescriptive authority, and to be immediately available at all times for supervision and consultation by a nurse practitioner; and

Whereas, Half of the states allow nurse practitioners to practice independently without physician supervision; and

Whereas, 70% of physicians are now employed by large groups, hospitals, private capital groups, insurance companies and ERISA-qualified managed care organizations which often care for patients in many states and employ non-physicians to assist in patient care, using many varying protocols for physician supervision of non-physician professionals, and assessment of an individual physician's competence; and

Whereas, Recent and continuing changes in the ownership and structure of physician practice can raise licensing issues related to conflicts of interest, anti-competitive activity, restraint of trade and interference with interstate commerce related to restriction of physician licensing; and

Whereas, Policy objectives for licensing and interstate health care delivery should incorporate the best practices of individual states, recognizing rapid evolution in the structure of health care delivery including current capabilities of telemedicine in various medical specialties and by non-physician professionals, into a single comprehensive policy that promotes accessible, quality,

affordable, appropriately accredited and accountable care, distributed to all members of our society; therefore be it

RESOLVED, That our American Medical Association address the issue of state licensure in a comprehensive manner including studying the best mechanisms to ensure interstate licensure for practitioners practicing in multiple states, optimizing state licensure practices to allow for seamless telemedicine practice across state lines, and addressing long delays in practitioners obtaining state licensures which lead to delays in medical care (Directive to Take Action); and be it further

RESOLVED, That our AMA research the feasibility of convening a meeting of appropriate stakeholders, including but not limited to state medical boards, medical specialty societies, state medical societies, payers, organizations representing non-physician medical professionals, Centers for Medicare and Medicaid Services-approved accrediting agencies, and patients to develop recommendations to modernize the state medical licensure system including creating mechanisms for multi-state licensure, streamlining the process of obtaining medical licensure, and facilitate practice across state lines (Directive to Take Action); and be it further

RESOLVED, That our AMA report back on these recommendations by the 2022 Interim Meeting. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/06/22

RELEVANT AMA POLICY

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950
Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
(2) The physician is responsible for managing the health care of patients in all practice settings.
(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.
Citation: (CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13)

Independent Practice of Medicine by Advanced Practice Registered Nurses H-35.988
Our AMA, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the states requirements for licensure to engage in the practice of medicine

and surgery in all of its branches. Our AMA opposes enactment of the Advanced Practice Registered Nurse (APRN) Multistate Compact, due to the potential of the APRN Compact to supersede state laws that require APRNs to practice under physician supervision, collaboration or oversight.
Citation: Sub. Res. 53, I-82; Reaffirmed: A-84; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 9, I-11; Modified: Res. 214, I-17; Modified: BOT Rep. 15, A-18

Physician Assistants and Nurse Practitioners H-160.947
Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.
The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):
(1) The physician is responsible for managing the health care of patients in all settings.
(2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
(3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
(4) The physician is responsible for the supervision of the physician assistant in all settings.
(5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
(6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
(7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.
Citation: BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Opposition to the Department of Veterans Affairs Proposed Rulemaking on APRN Practices D-35.979
1. Our AMA will express to the U.S. Department of Veterans Affairs (VA) that the plan to substitute physicians by using Advanced Practice Registered Nurses (APRNs) in independent practice, not in physician-led teams, is antithetical to multiple established policies of our AMA and thus should not be implemented.
2. Our AMA staff will assess the feasibility of seeking federal legislation that prevents the VA from enacting regulations for veterans' medical care that is not consistent with physician-led health care teams or to mandate that the VA adopt policy regarding the same.
3. Our AMA will call upon Congress and the Administration to disapprove or otherwise overturn rules and regulations at the federal level that would expand the scope of practice of APRNs, and comment to the Director of Regulation Management within the Department of Veterans Affairs of this position during the current comment period.
4. Our AMA will collaborate with other medical professional organizations to vigorously oppose the final adoption of the VA's proposed rulemaking expanding the role of APRNs within the VA.
Citation: Res. 239, A-16

COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963
Our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; (2) will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care.
Citation: Alt. Res. 203, I-20; Reaffirmed: CMS Rep. 7, A-21

Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980

Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.
Citation: Res. 208, I-18; Reaffirmed: CMS Rep. 7, A-21

Established Patient Relationships and Telemedicine D-480.964
Our AMA will:
1) work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact as a means of enhancing patient access to and proper regulation of telemedicine services;
(2) advocate to the Interstate Medical Licensure Compact Commission and Federation of State Medical Boards for reduced application fees and secondary state licensure(s) fees processed through the Interstate Medical Licensure Compact;
(3) work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services, in accordance with AMA Policy H-480.946, "Coverage of and Payment for Telemedicine"; and
(4) continue to support state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in Policy H-480.946.
Citation: CMS Rep. 1, I-19; Appended: CMS Rep. 8, A-21

State Authority and Flexibility in Medical Licensure for Telemedicine D-480.999
Our AMA will continue its opposition to a single national federalized system of medical licensure.
Citation: (CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: BOT Rep. 3, I-14)

Principles of and Actions to Address Primary Care Workforce H-200.949
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.

11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
Citation: CME Rep. 04, I-18

Telemedicine Encounters by Third Party Vendors D-480.968
1. Our AMA will develop model legislation and/or regulations requiring telemedicine services or vendors to coordinate care with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and/or treating physicians and providing to the treating physician a copy of the medical record, with the patient's consent.
2. The model legislation and/or regulations will also require the vendor to abide by laws addressing the privacy and security of patients' medical information
3. Our AMA will include in that model state legislation the following concepts based on AMA policy: (a) A valid patient-physician relationship must be established before the provision of telemedicine services; (b) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (c) The standards and scope of telemedicine services should be consistent with related in-person services.
4. Our AMA will educate and advocate to AMA members on the use and implementation of telemedicine and other related technology in their practices to improve access, convenience, and continuity of care for their patients.
Citation: Res. 234, A-16

The Promotion of Quality Telemedicine H-480.969
(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:
(a) exemption from such a licensure requirement for physician-to-physician consultations;
(b) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient;
(c) allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified; and
(d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.
(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions.
(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties).
Citation: CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed: BOT Rep. 22, A-13; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed: CMS Rep. 1, I-19; Modified: CMS Rep. 8, A-21

Coverage of and Payment for Telemedicine H-480.946
1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:
a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
- A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
- A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
- Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.
Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
e) The delivery of telemedicine services must be consistent with state scope of practice laws.
f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
g) The standards and scope of telemedicine services should be consistent with related in-person services.
h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
j) The patient's medical history must be collected as part of the provision of any telemedicine service.
k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.
m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.
2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.
3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.
4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.
5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.
6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.
7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.
Citation: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed in lieu of Res. 815, I-15; Reaffirmed: CME Rep. 06, A-16; Reaffirmed: CMS Rep. 06, I-16; Reaffirmed: Res. 111, A-17; Reaffirmation: A-18; Reaffirmed: CMS Rep. 1, I-19; Reaffirmed: CMS Rep. 8, A-21

Evolving Impact of Telemedicine H-480.974
Our AMA:
(1) will evaluate relevant federal legislation related to telemedicine;
(2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
(3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
(4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
(5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
(6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
(7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;
(8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
(9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted.

Citation: CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 805, I-12; Appended: BOT Rep. 26, A-13; Modified: BOT Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A-16; Reaffirmation: A-18

Addressing Equity in Telehealth H-480.937
Our AMA:
(1) recognizes access to broadband internet as a social determinant of health;
(2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations;
(3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations;
(4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities;
(5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth;
(6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations;
(7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth;
(8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians; and
(9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.
Citation: CMS Rep. 7, A-21

1.2.12 Ethical Practice in Telemedicine
Innovation in technology, including information technology, is redefining how people perceive time and distance. It is reshaping how individuals interact with and relate to others, including when, where, and how patients and physicians engage with one another.
Telehealth and telemedicine span a continuum of technologies that offer new ways to deliver care. Yet as in any mode of care, patients need to be able to trust that physicians will place patient welfare above other interests, provide competent care, provide the information patients need to make well-considered decisions about care, respect patient privacy and confidentiality, and take steps to ensure continuity of care. Although physicians fundamental ethical responsibilities do not change, the continuum of possible patient-physician interactions in telehealth/telemedicine give rise to differing levels of accountability for physicians.
All physicians who participate in telehealth/telemedicine have an ethical responsibility to uphold fundamental fiduciary obligations by disclosing any financial or other interests the physician has in the telehealth/telemedicine application or service and taking steps to manage or eliminate conflicts of interests. Whenever they provide health information, including health content for websites or mobile health applications, physicians must ensure that the information they provide or that is attributed to them is objective and accurate.
Similarly, all physicians who participate in telehealth/telemedicine must assure themselves that telemedicine services have appropriate protocols to prevent unauthorized access and to protect the security and integrity of patient information at the patient end of the electronic encounter, during transmission, and among all health care professionals and other personnel who participate in the telehealth/telemedicine service consistent with their individual roles.
Physicians who respond to individual health queries or provide personalized health advice electronically through a telehealth service in addition should:
(a) Inform users about the limitations of the relationship and services provided.
(b) Advise site users about how to arrange for needed care when follow-up care is indicated.
(c) Encourage users who have primary care physicians to inform their primary physicians about the online health consultation, even if in-person care is not immediately needed.
Physicians who provide clinical services through telehealth/telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. In the context of telehealth/telemedicine they further should:
(d) Be proficient in the use of the relevant technologies and comfortable interacting with patients and/or surrogates electronically.

(e) Recognize the limitations of the relevant technologies and take appropriate steps to overcome those limitations. Physicians must ensure that they have the information they need to make well-grounded clinical recommendations when they cannot personally conduct a physical examination, such as by having another health care professional at the patients site conduct the exam or obtaining vital information through remote technologies.
(f) Be prudent in carrying out a diagnostic evaluation or prescribing medication by:
(i) establishing the patients identity;
(ii) confirming that telehealth/telemedicine services are appropriate for that patients individual situation and medical needs;
(iii) evaluating the indication, appropriateness and safety of any prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction; and
(iv) documenting the clinical evaluation and prescription.
(g) When the physician would otherwise be expected to obtain informed consent, tailor the informed consent process to provide information patients (or their surrogates) need about the distinctive features of telehealth/telemedicine, in addition to information about medical issues and treatment options. Patients and surrogates should have a basic understanding of how telemedicine technologies will be used in care, the limitations of those technologies, the credentials of health care professionals involved, and what will be expected of patients for using these technologies.
(h) As in any patient-physician interaction, take steps to promote continuity of care, giving consideration to how information can be preserved and accessible for future episodes of care in keeping with patientspreferences (or the decisions of their surrogates) and how follow-up care can be provided when needed. Physicians should assure themselves how information will be conveyed to the patients primary care physician when the patient has a primary care physician and to other physicians currently caring for the patient.
Collectively, through their professional organizations and health care institutions, physicians should:
(i) Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.
(j) Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.
(k) Routinely monitor the telehealth/telemedicine landscape to:
(i) identify and address adverse consequences as technologies and activities evolve; and
(ii) identify and encourage dissemination of both positive and negative outcomes.
AMA Principles of Medical Ethics: I,IV,VI,IX
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(A-22)

Introduced by: Medical Student Section

Subject: Advocating for the Elimination of Hepatitis C Treatment Restrictions

Referred to: Reference Committee B

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1 Whereas, An estimated 2.4 million Americans are living with Hepatitis C Virus (HCV) infection,
2 and acute HCV infection rates doubled from 2012 to 2019[1,2]; and
3
4 Whereas, Even with improvements in HCV treatment, projections for the next 35 years estimate
5 that 157,000 U.S. patients will develop hepatocellular carcinoma, 203,000 will develop
6 decompensated cirrhosis, and 320,000 will die due to HCV[3]; and
7
8 Whereas, The prevalence of HCV among Medicaid enrollees is 7.5 times higher than
9 prevalence among the commercially insured population, demonstrating the disproportionate
10 impact of HCV on marginalized populations[4]; and
11
12 Whereas, Structural barriers to accessing HCV therapy persist, as many state Medicaid
13 programs, prisons and jails, and private insurers implement non-medically indicated restrictions,
14 including *fibrosis restrictions* (requirement that patients have severe liver damage before
15 receiving HCV treatment coverage), *sobriety restrictions* (requirement of abstinence from drugs
16 and/or alcohol before HCV treatment), and *prescriber restrictions* (limitations on the type of
17 clinician that can prescribe HCV treatment, such as requiring primary care doctors to consult
18 with or request direct prescription from a hepatologist)[5,6]; and
19
20 Whereas, Consensus guidelines from the American Association for the Study of Liver Diseases
21 (AASLD) and the Infectious Diseases Society of America (IDSA) recommend with Level 1A
22 evidence that nearly all people with acute or chronic HCV should receive treatment with direct-
23 acting antivirals (DAAs), which can cure over 95% of individuals with HCV[7]; and
24
25 Whereas, The AASLD/IDSA guidelines emphasize with Level 1A evidence that "there are no
26 data to support the utility of pretreatment screening for illicit drug or alcohol use in identifying a
27 population more likely to successfully complete HCV therapy"[7]; and
28
29 Whereas, The AASLD/IDSA guidelines emphasize with Level 1A evidence that initiating therapy
30 in patients with lower-stage fibrosis augments the clinical and public health benefits of virologic
31 cure, and treatment delay may decrease the benefit of virologic cure[7]; and
32
33 Whereas, While treatment restrictions were primarily created to help payors mitigate the high
34 cost of HCV treatment regimens, numerous studies have demonstrated that these restrictive
35 policies are more costly and less effective than unrestricted strategies[8-13]; and
36
37 Whereas, In spite of expert consensus that HCV treatment restrictions are neither medically
38 indicated nor effective, as of April 2021, four states still have fibrosis restrictions, 28 states have
39 sobriety restrictions, and 18 states have prescriber restrictions[5,6]; and

Whereas, A 2018 study found that 35.5% of patients across 45 states (including 52.4% of commercial enrollees, 34.5% of Medicaid enrollees, and 14.7% of Medicare enrollees) who received prescriptions for DAAs were denied DAA coverage due to fibrosis, sobriety, or prescriber restrictions[14]; and

Whereas, The wholesale cost of a DAA treatment course has dropped over the last decade from $80,000+ to as low as $20,000[15]; and

Whereas, The Centers for Medicare and Medicaid Services issued a letter to states in 2015 that HCV treatment access restrictions may violate Medicaid statutory requirements[16]; and

Whereas, The U.S. Department of Health and Human Services' Viral Hepatitis National Strategic Plan for 2021-2025 includes a disparities goal of reducing the proportion of states with fibrosis, sobriety, and prescriber restrictions[17]; and

Whereas, Restricted access to HCV treatment disproportionately exacerbates health and financial inequities for American Indian/Alaska Native (AIAN) populations, who face double the acute HCV incidence rates of non-Hispanic whites and the highest rates of HCV-related mortality of any racial/ethnic group, as well as other structurally vulnerable immigrant and minoritized communities[18-20]; and

Whereas, While there is a legal responsibility to provide healthcare to AIAN patients served by the Indian Health Service (IHS), the agency serves as a payor of last resort, meaning federal and state-level coverage restrictions (i.e., via Medicare and Medicaid) can adversely impact IHS and AIAN populations[20-23]; and

Whereas, Our AMA supports increased funding and negotiation for affordable pricing of HCV treatment "so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment" (H-440.845), which should include nearly all people with HCV in accordance with expert guidelines[7]; therefore be it

RESOLVED, That our American Medical Association amend policy H-440.845, "Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment," by addition to read as follows:

Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment, H-440.845

Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC, Indian Health Service (IHS), and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) advocate, in collaboration with state and specialty medical societies, as well as patient advocacy groups, for the elimination of sobriety requirements, fibrosis restrictions, and prescriber restrictions for coverage of HCV treatment by public and private payors; (5~~4~~) support programs aimed at training providers in the treatment and management of patients infected with HCV; (6~~5~~) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies, and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment;

(7~~6~~) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; (8~~7~~) encourage equitable reimbursement for those providing treatment; (9) encourage the allocation of targeted funding to increase HCV treatment for IHS patients insured by plans subject to HCV treatment restrictions. (Modify Current HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

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RELEVANT AMA POLICY

Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H-440.845
Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support programs aimed at training providers in the treatment and management of patients infected with HCV; (5) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies, and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; (6) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; and (7) encourage equitable reimbursement for those providing treatment.
Citation: Res. 906, I-12; Modified: Res. 511, A-15; Modified: Res. 410, A-17

Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons H-430.985
Our AMA: (1) supports the implementation of routine screening for Hepatitis C virus (HCV) in prisons; (2) will advocate for the initiation of treatment for HCV when determined to be appropriate by the treating physician in incarcerated patients with the infection who are seeking treatment; and (3) supports negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications.
Citation: Res. 404, A-17

Incorporating Value into Pharmaceutical Pricing H-110.986
1. Our AMA supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.
2. Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research.
3. Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.
Citation: CMS Rep. 05, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS-CSAPH Rep. 01, A-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: CSAPH Rep. 2, I-19; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 6, I-20

US Physician Shortage H-200.954
Our AMA:
(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
(13) will work to augment the impact of initiatives to address rural physician workforce shortages.
Citation: Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08; Appended: CME Rep. 4, A-10; Appended: CME Rep. 16, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 922, I-13; Modified: CME Rep. 7, A-14; Reaffirmed: CME Rep. 03, A-16; Appended: Res. 323, A-19; Appended: CME Rep. 3, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(A-22)

Introduced by: Resident and Fellow Section

Subject: Preserving the Practice of Medicine

Referred to: Reference Committee B

Whereas, The book *Patients at Risk: The Rise of the Nurse Practitioner and Physician Assistant in Healthcare* by Niran Al-Agba, M.D. and Rebekah Bernard, M.D. published in 2020, seeks to educate patients about the safety of the providers treating them and empower physicians to regain control of the practice of medicine[1]; and

Whereas, The corporatization of medicine, at the expense of quality safe healthcare, has led to physicians being replaced by non-physician providers, especially in states with legislatively-enshrined independent practice for non-physician providers[1]; and

Whereas, News reports and articles note instances of thoracic surgeons and obstetrician gynecologists supervising social workers in the provision of group therapy[2] and plastic surgeons supervising physician assistants who advertise themselves as “dermatologists”[3]; and

Whereas, Anecdotal evidence suggests numerous non-physician providers practicing in various fields with nominal supervision by physicians who are not trained in those fields; and

Whereas, Physicians without appropriate training to supervise non-physician providers outside of their expertise defeats the purpose of scope-of-practice laws, endangering patients; and

Whereas, Studies show that care provided by non-physician providers is more expensive and invasive due to more frequent office visits, lab testing, imaging and home visits[4,5]; and

Whereas, No credible controlled trial has been performed to evaluate the quality of care provided by non-physicians vs. physicians in settings that are truly characterized as “independent practice”[5]; and

Whereas, Non-physician providers seeking independent practice inaccurately cite studies to claim non-physicians supervised by physicians have equal outcomes to physicians[5], and

Whereas, An increasing number of healthcare organizations preferentially fill the schedules of non-physician providers over physicians to increase profit[5]; and

Whereas, There are efforts by the National Organization of Nurse Practitioners Faculties by 2025 to convert Master of Science in Nursing (MSN) degrees into Doctor of Nursing Practice degrees (DNP), many of which are online programs without clear standards of curricula[6]; therefore be it

RESOLVED, That our American Medical Association oppose mandates from employers to supervise non-physician providers as a condition for physician employment and in physician employment contracts (New HOD Policy); and be it further

RESOLVED, That our AMA work with relevant regulatory agencies to ensure physicians are notified in writing when their license is being used to “supervise” non-physician providers (Directive to Take Action); and be it further

RESOLVED, That our AMA conduct a systematic study to collect and analyze publicly available physician supervision data from all sources to determine how many allied health professionals are being supervised by physicians in fields which are not a core part of those physicians’ completed residencies and fellowships (Directive to Take Action); and be it further

RESOLVED, That our AMA study the impact scope-of practice advocacy by physicians has had on physician employment and termination (Directive to Take Action); and be it further

RESOLVED, That our AMA study the views of patients on physician and non-physician care to identify best practices in educating the general population on the value of physician-led care, and study the utility of a physician-reported database to track and report institutions that replace physicians with non-physician providers in order to aid patients in seeking physician-led medical care (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to commission an independent study comparing medical care provided by physician-led health care teams vs. care provided by unsupervised non-physician providers, which reports on the quality of health outcomes, cost effectiveness, and access to necessary medical care, and to publish the findings in a peer-reviewed medical journal. (Directive to Take Action)

Fiscal Note: Estimated cost of $462,000 to implement this resolution.

Received: 04/08/22

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6. NP to DNP: In Less Than 10 Years, All Nurse Practitioners May Need to Hold a DNP - Regis College Online

RELEVANT AMA POLICY

Practicing Medicine by Non-Physicians H-160.949

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;
(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or

appropriate physician (MD, DO) supervision;
(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and
(6) opposes special licensing pathways for “assistant physicians” (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program, or have not completed at least one year of accredited graduate medical education in the U.S).
Citation: Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 224, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Res. 107, A-14; Appended: Res. 324, A-14; Modified: CME Rep. 2, A-21;

Physician Assistants and Nurse Practitioners H-160.947
Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.
The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):
(1) The physician is responsible for managing the health care of patients in all settings.
(2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
(3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
(4) The physician is responsible for the supervision of the physician assistant in all settings.
(5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
(6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
(7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.
Citation: BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950
Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
(2) The physician is responsible for managing the health care of patients in all practice settings.
(3) Health care services delivered in an integrated practice must be within the scope of each

practitioner's professional license, as defined by state law.
(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.
Citation: (CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13)

Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice H-360.987
Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care.
(2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team.
(3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians.

(4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team.
(5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities.
(6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.
Citation: (BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-12; Reaffirmed: BOT Rep. 16, A-13)

Practice Agreements Between Physicians and Advance Practice Nurses and the Physician to Advance Practice Nurse Supervisory Ratio H-35.969

Our AMA will: (1) continue to work with the Federation in developing necessary state advocacy resource tools to assist the Federation in: (a) addressing the development of practice agreements between practicing physicians and advance practice nurses, and (b) responding to or developing state legislation or regulations governing these practice agreements, and that the AMA make these tools available on the AMA Advocacy Resource Center Web site; and (2) support the development of methodologically valid research comparing physician-APRN practice agreements and their respective effectiveness.
Citation: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 09, A-19;

Regulation of Advanced Practice Nurses H-35.964
1. AMA policy is that advanced practice registered nurses (APRNs) should be subject to the jurisdiction of state medical licensing and regulatory boards for regulation of their performance of medical acts.
2. Our AMA will develop model legislation to create a joint regulatory board composed of members of boards of medicine and nursing, with authority over APRNs.
Citation: BOT Action in response to referred for decision Amendment B-3 to Res. 233 A-17

Protecting Physician Led Health Care H-35.966
Our American Medical Association will continue to work with state and specialty medical associations and other organizations to collect, analyze and disseminate data on the expanded use of allied health professionals, and of the impact of this practice on healthcare access (including in poor, underserved, and rural communities), quality, and cost in those states that permit independent practice of allied health professionals as compared to those that do not. This analysis should include consideration of practitioner settings and patient risk-adjustment.
Citation: Res. 238, A-15; Reaffirmed: BOT Rep. 20, A-17;

Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital H-35.978
The AMA encourages hospital medical staffs to have a process whereby physicians will have input to and provide review of education programs provided by their hospital for the benefit of allied health professionals working in that hospital, for the education of patients served by that hospital, and for outpatient educational programs provided by that hospital.
Citation: (BOT Rep. B, A-93; Adopts Res. 317, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)

Health Workforce H-200.994
The AMA endorses the following principle on health manpower: Both physicians and allied health professionals have legal and ethical responsibilities for patient care, even though ultimate responsibility for the individual patient's medical care rests with the physician. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency.
Citation: (BOT Rep. C, I-81; Reaffirmed: Sunset Report, I-98; Modified: CME Rep. 2, I-03; Reaffirmed: CME Rep. 2, A-13)

Health Care Quality Improvement Act of 1986 Amendments H-275.965
The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists.
Citation: (Res. 203, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(A-22)

Introduced by: American Association of Physicians of Indian Origin

Subject: Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas

Referred to: Reference Committee B

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1 Whereas, J-1 visa IMG resident physicians sign in for serving in underserved areas for three
2 years to become eligible to stay in US as permanent residents instead of mandatory return to
3 native countries as required per J-1 visa regulation; and
4
5 Whereas, Their service is extremely helpful in improving the health of US citizens especially in
6 low income and rural communities; and
7
8 Whereas, Substantial care to COVID patients was provided by these J-1 visa waiver physicians
9 and they saved lives; and
10
11 Whereas, The waiting period for getting the Green Card Visa for physicians of certain countries
12 is longer than 10 years at present due to per country limit of 7% of H1b to immigrant (Green
13 Card) availability, and the J-1 visa waiver physicians have to join the end of the very long queue
14 of 1.2 million applicants for certain countries, and their children are becoming status less at
15 age 21; and
16
17 Whereas, These J-1 visa waiver physicians provide a great national service to US citizens, and
18 deserve priority in visa allotment; therefore be it
19
20 RESOLVED, That our American Medical Association lobby US Congress and the US
21 Administration that the J-1 visa waiver physicians serving in underserved areas be given highest
22 priority in visa conversion to green cards upon completion of their service commitment
23 obligation and be exempted from per country limitation of H-1 to green card visa conversion.
24 (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/20/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(A-22)

Introduced by: American College of Emergency Physicians

Subject: Due Process and Independent Contractors

Referred to: Reference Committee B

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1 Whereas, Physicians often hesitate to speak out because of the prospect of losing their jobs or
2 suffering other types of retaliation due to a possible or real threat if they expressed concerns
3 about quality of care[1]; and
4
5 Whereas, Physicians have been retaliated against numerous times for raising concerns
6 regarding patient safety, harassment, and/or fraud and these physicians have been affected
7 mentally and financially as results of such retaliation and job loss and many report worsening
8 anxiety, depression, financial hardships, family trouble and need to relocate[2]; and
9
10 Whereas, The interests of patients are best served when physicians practice in a stable, fair,
11 equitable, and supportive environment and quality patient care is best promoted within a
12 framework of fair and appropriate contractual relationships among various involved parties; and
13
14 Whereas, The COVID-19 pandemic put to the test physicians' ability to speak publicly about
15 troublesome issues and in the first few weeks, healthcare facilities were struggling to obtain
16 personal protective equipment (PPE) and to create policies that would keep patients and
17 caregivers safe[3,4]; and
18
19 Whereas, The Joint Commission and the Health Care Quality Improvement Act of 1986 require
20 hospitals to give physicians appropriate due process before taking an adverse action on their
21 privileges; and
22
23 Whereas, There are also a number of state and federal laws that protect employees from
24 discrimination or retribution for "whistle-blowing," but these protections may be weakened or
25 inapplicable if the physician is an independent contractor[5]; and
26
27 Whereas, Our AMA Principles for Physician Employment (H-225.950) states in part "Employed
28 physicians should be free to exercise their personal and professional judgment in voting,
29 speaking and advocating on any manner regarding patient care interests, the profession, health
30 care in the community, and the independent exercise of medical judgment. Employed
31 physicians should not be deemed in breach of their employment agreements, nor be retaliated

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[1] McNamara RM, Beier K, Blumstein H, Weiss LD, Wood J. A survey of emergency physicians regarding due process, financial pressures, and the ability to advocate for patients. J Emerg Med. 2013 Jul;45(1):111-6.e3. doi: 10.1016/j.jemermed.2012.12.019. Epub 2013 Apr 18. PMID: 23602793.
[2] https://www.nbcnews.com/health/health-care/doctor-fired-er-warns-effect-profit-firms-us-health-care-rcna19975?utm_source=pocket_mylist (last accessed April 6, 2022)
[3] https://www.medscape.com/viewarticle/950074
[4] https://verdictsearch.com/verdict/hospitals-firing-of-doctor-was-retaliation-plaintiff-alleged/
https://www.reliasmedia.com/articles/146234-enforcement-action-likely-if-hospital-retaliates-against-ed-staff
https://www.npr.org/sections/health-shots/2020/05/29/865042307/an-er-doctor-lost-his-job-after-criticizing-his-hospital-on-covid-19-now-hes-sui
[5] https://www.aaemrsa.org/get-involved/residents/key-contract-issues

against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization;" and

Whereas, The State of Arizona recently passed Arizona House Bill 2622 (2021) to address many of these concerns, and several other states have enacted similar legislation, each with their own strengths and weaknesses; and

Whereas, Our AMA policies are silent on those physicians who work as independent contractors and might be subject to retaliatory actions by their contractors rather than their employer; therefore be it

RESOLVED, That our American Medical Association develop a model state legislative template and principles for federal legislation in order to protect physicians from corporate, workplace, and/or employer retaliation when reporting safety, harassment, or fraud concerns at the places of work (licensed health care institution) or in the government, which includes independent and third-party contractors providing patient services at said facilities. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/27/22

RELEVANT AMA POLICY

AMA Principles for Physician Employment H-225.950

1. Addressing Conflicts of Interest

a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.

c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and

(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.

e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative

leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession

a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.

b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.

c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.

d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.

e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.

(f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:

i. The agreement is for the provision of services on an exclusive basis; and

ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and

iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

BOT Rep. 6, I-12 Reaffirmed: CMS Rep. 6, I-13 Modified in lieu of Res. 2, I-13 Modified: Res. 737, A-14 Reaffirmed: BOT Rep. 21, A-16 Reaffirmed: CMS Rep. 05, A-17 Reaffirmed: CMS Rep. 07, A-19 Reaffirmed: CMS Rep. 11, A-19 Modified: BOT Rep. 13, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(A-22)

Introduced by: Aerospace Medical Association

Subject: Vital Nature of Board-Certified Physicians in Aerospace Medicine

Referred to: Reference Committee B

Whereas, Aerospace medicine is an internationally recognized, unique specialty of medicine with advanced education requirements supporting all domains of aviation and space flight; and

Whereas, In over a century of support, the Aerospace Medicine Team, led by aerospace medicine physicians, has advanced the art and science of every human flight endeavor, resulting in improved safety, reduced mishaps, and enhanced mission accomplishment; and

Whereas, Aerospace medicine physicians are required to maintain their professional knowledge and standing with state medical licensure, current specialty board certifications, continuing medical education activities, and ongoing privileging; and have extensive knowledge, skills, and professional self-regulation in the full and total range of the practice of aerospace medicine; and

Whereas, In an effort to reduce costs and pass-on legal liability, there has been a trend in managed medical care, US commercial airlines/space activities and in the US governmental departments to replace aerospace medicine physicians with non-aerospace medicine and mid-level providers, resulting in significantly increased risk and reduced safety margins; and

Whereas, 193 countries are signatories to the Convention on International Civil Aviation (“Chicago Convention”), which obliges the governments to reciprocally implement certain international regulatory standards, including physician responsibility pertaining to medical fitness of license holders, prevention of ill health and management of public health events in aviation; therefore be it

RESOLVED, That our American Medical Association recognize the unique contributions and advanced qualifications of aerospace medicine professionals, and specifically oppose any and all efforts to remove, reduce or replace aerospace medicine physician leadership in civilian, corporate or government aerospace medicine programs and aircrew healthcare support teams; (Directive to Take Action) and be it further

RESOLVED, That our AMA advocate for compliance with international agreements, to include advocating against other mid-level provider scope of practice expansions that threaten the safety, health, and well-being of aircrew, patients, support personnel and the flying public. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/25/22

RELEVANT AMA POLICY

The Structure and Function of Interprofessional Health Care Teams H-160.912
1. Our AMA defines 'team-based health care' as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.
2. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that she or he is trained to perform.
3. Our AMA will advocate that all members of a physician-led interprofessional health care team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.
4. Our AMA adopts the following principles to guide physician leaders of health care teams:
a. Focus the team on patient and family-centered care.
b. Make clear the team's mission, vision and values.
c. Direct and/or engage in collaboration with team members on patient care.
d. Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
e. Foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
f. Encourage adherence to best practice protocols that team members are expected to follow.
g. Manage care transitions by the team so that they are efficient and effective, and transparent to the patient and family.
h. Promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.
i. Support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group or network.
j. Facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation.
k. Review measures of 'population health' periodically when the team is responsible for the care of a defined group.
5. Our AMA encourages independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks or other networks of independent providers.
6. Our AMA will advocate that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members.
Citation: Joint CME-CMS Rep., I-12; Reaffirmation I-13; Reaffirmed: CMS Rep. 1, I-15; Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17

Models / Guidelines for Medical Health Care Teams H-160.906
1. Our AMA defines 'physician-led' in the context of team-based health care as the consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.
2. Our AMA supports the following elements that should be considered when planning a team-based care model according to the needs of each physician practice:
Patient-Centered:

a. The patient is an integral member of the team.
b. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.
c. Patient and family-centered care is prioritized by the team and approved by the physician team leader.
d. Team members are expected to adhere to agreed-upon practice protocols.
e. Improving health outcomes is emphasized by focusing on health as well as medical care.
f. Patients' access to the team, or coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week.
g. Safety protocols are developed and followed by all team members.
Teamwork:
h. Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team.
i. All practitioners commit to working in a team-based care model.
j. The number and variety of practitioners reflects the needs of the practice.
k. Practitioners are trained according to their unique function in the team.
l. Interdependence among team members is expected and relied upon.
m. Communication about patient care between team members is a routine practice.
n. Team members complete tasks according to agreed-upon protocols as directed by the physician leader.
Clinical Roles and Responsibilities:
o. Physician leaders are focused on individualized patient care and the development of treatment plans.
p. Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.
q. Care coordination and case management are integral to the team's practice.
r. Population management monitors the cost and use of care, and includes registry development for most medical conditions.
Practice Management:
s. Electronic medical records are used to the fullest capacity.
t. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments.
u. Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling.
v. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.
Citation: CMS Rep. 6, A-14; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 05, A-17

Payment Mechanisms for Physician-Led Team-Based Health Care H-160.908
1. Our AMA advocates that physicians who lead team-based care in their practices receive the payments for health care services provided by the team and establish payment disbursement mechanisms that foster physician-led team-based care.
2. Our AMA advocates that payment models for physician-led team-based care should be determined by physicians working collaboratively with hospital and payer partners to design models best suited for their particular circumstances.
3. Our AMA advocates that physicians make decisions about payment disbursement in consideration of team member contributions, including but not limited to:
a. Volume of services provided;
b. Intensity of services provided;
c. Profession of the team member;
d. Training and experience of the team member; and

e. Quality of care provided.
4. Our AMA advocates that an effective payment system for physician-led team-based care should:
a. Reflect the value provided by the team and that any savings accrued by this value should be shared by the team;
b. Reflect the time, effort and intellectual capital provided by individual team members;
c. Be adequate to attract team members with the appropriate skills and training to maximize the success of the team; and
d. Be sufficient to sustain the team over the time frame that it is needed.
Citation: CMS Rep. 1, I-13; Reaffirmed: CMS Rep. 1, I-15; Reaffirmed: CMS Rep. 08, A-16

Support for Physician Led, Team Based Care D-35.985
Our AMA:
1. Reaffirms, will proactively advance at the federal and state level, and will encourage state and national medical specialty societies to promote policies H-35.970, H-35.973, H-35.974, H-35.988, H-35.989, H-35.992, H-35.993, H-160.919, H-160.929, H-160.947, H-160.949, H-160.950, H-360.987, H 405.969 and D-35.988.
2. Will identify and review available data to analyze the effects on patients' access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.
3. Will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.
4. Will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.
5. Will continue to recognize non-physician providers as valuable components of the physician-led health care team.
6. Will continue to advocate that physicians are best qualified by their education and training to lead the health care team.
7. Will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.
Citation: BOT Rep. 9, I-11; Reaffirmed: CMS Rep. 1, A-12; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 6, A-21

Reference Committee C

CME Report(s)

01 Council on Medical Education Sunset Review of 2012 House Policies

02 An Update on Continuing Board Certification

03 Onsite and Subsidized Childcare for Medical Students, Residents and Fellows

04 Protection of Terms Describing Physician Education and Practice

05 Education, Training and Credentialing of Non-Physician Health Care Providers and Their Impact on Physician Education and Training

06 Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows

Resolution(s)

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

302 Resident and Fellow Access to Fertility Preservation

303 Fatigue Mitigation Respite for Faculty and Residents

304 Organizational Accountability to Resident and Fellow Trainees

305 Reducing Overall Fees and Making Costs for Licensing Exam Fees, Application Fees, Etc., Equitable for IMGs

306 Creating a More Accurate Accounting of Medical Education Financial Costs

307 Parental Leave and Planning Resources for Medical Students

308 University Land Grant Status in Medical School Admissions

309 Decreasing Bias in Evaluations of Medical Student Performance

310 Support for Standardized Interpreter Training

311 Discontinue State Licensure Requirement for COMLEX Level 2 PE

312 Reduce Financial Burden to Medical Students of Medical Licensure Examinations

313 Decreasing Medical Student Debt and Increasing Transparency in Cost of Medical School Attendance

314 Support for Institutional Policies for Personal Days for Undergraduate Medical Students

315 Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program

316 Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools

317 Medical Student, Resident and Fellow Suicide Reporting

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-A-22

Subject: Council on Medical Education Sunset Review of 2012 House Policies

Presented by: Niranjan V. Rao, MD, Chair

Referred to: Reference Committee C

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association policies to ensure that our AMA's policy database is current, coherent, and relevant:

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

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

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

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

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

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

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RECOMMENDATION

The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: $1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
H-35.975	Ratio of Physician to Physician Extenders	Our AMA endorses the principle that the appropriate ratio of physician to non-physician practitioners should be determined by physicians at the practice level, consistent with good medical practice, and state law where relevant, taking into consideration the physician's specialty, physician's panel size and disease burden of the patient case mix. (CME Rep. 10, I-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed: BOT Rep. 28, A-09; Modified: Joint CME-CMS Rep., I-12)	Retain; still relevant.
H-160.940	Free Clinic Support	Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics; and (2) efforts to reduce the barriers faced by physicians volunteering in free clinics, including medical liability coverage under the Federal Tort Claims Act, liability protection under state and federal law, and state licensure provisions for retired physicians and physicians licensed in other United States jurisdictions. (Sub. Res. 113, I-96; Reaffirmed: BOT 17, A-04; CMS Rep. 1, A-09; Reaffirmed in lieu of Res. 105, A-12; Appended: CME Rep. 6, A-12)	Retain; still relevant. In addition, revise to incorporate relevant principles of H-160.953, "Free Clinics," which is rescinded through this report. Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics, to include potential partnerships with state and county medical societies to establish a jointly sponsored free clinic pilot program; and (2) efforts to reduce the barriers faced by physicians volunteering in free clinics, including medical liability coverage under the Federal Tort Claims Act, liability protection under state and federal law, and state licensure provisions for retired physicians and physicians licensed in other United States jurisdictions, in partnership with state and county medical societies; medical liability insurance providers; and state, county, and local government.
H-160.953	Free Clinics	The AMA: (1) encourages the establishment of free clinics as an immediate partial solution to providing access to health care for indigent and underserved populations; (2) will explore the potential for a	Rescind and incorporate relevant principles into H-160.940, Free Clinic Support, as shown above. Clause 1 is already reflected in H-160.940 (1), which reads:

		partnership with state and county medical societies to establish a jointly-sponsored free clinic pilot program to provide health services and information to indigent and underserved populations; and (3) will develop strategies that will allow the AMA, along with one or more state or county medical societies, to join in partnership with private sector liability insurers and government - especially at the state, county, and local levels - to establish programs that will have appropriate levels of government pay professional liability premiums or indemnify physicians who deliver free services in free clinics or otherwise provide free care to the indigent. (BOT Rep. 27-A-94; Reaffirmed: BOT 17, A-04; Reaffirmed: CME Rep. 6, A-12)	Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics. Relevant segments of clauses 2 and 3 are incorporated into clauses 1 and 2 of H-160.940, as shown above.
H-275.922	Short-Term Physician Volunteer Opportunities Within the United States	Our AMA encourages the Federation of State Medical Boards to develop model policy for state licensure boards to streamline and standardize the process by which a physician who holds an unrestricted license in one state/district/territory may participate in physician volunteerism in another US state/district/territory in which the physician volunteer does not hold an unrestricted license. (Sub. Res. 915, I-10; Appended: CME Rep. 6, A-12)	Rescind and incorporate into D-275.984, "Licensure and Liability for Senior Physician Volunteers," as shown below.
D-275.984	Licensure and Liability for Senior Physician Volunteers	Our AMA (1) and its Senior Physician Group will inform physicians about special state licensing regulations for volunteer physicians; and (2) will support and work with state medical licensing boards and other appropriate agencies, including the sharing of model state legislation, to establish special reduced-fee volunteer medical license for	Retain; still relevant. In addition, revise to append information from similar policy, H-275.922, "Short-Term Physician Volunteer Opportunities Within the United States," which is rescinded through this report. Also, revise the title of this policy to remove references to senior physicians, as it now reflects all physician volunteers, regardless of age.

		those who wish to volunteer their services to the uninsured or indigent. (BOT Rep. 17, A-04; Reaffirmed: CCB/CLRPD Rep. 1, A-14)	Licensure and Liability for ~~Senior~~ Physician Volunteers Our AMA ~~(1) and its Senior Physician Group~~ will (1) inform physicians about special state licensing regulations for volunteer physicians providing their services to the uninsured or indigent; and (2) will support and work with state medical licensing boards and other appropriate agencies, including the Federation of State Medical Boards, to develop ~~sharing of~~ model policy and state legislation~~,~~ to (a) streamline and standardize the process by which a physician who holds an unrestricted license in one state/district/territory may participate in physician volunteerism in another U.S. state/district/territory in which the individual does not hold an unrestricted license and (b) establish special reduced-fee volunteer medical licenses for those who wish to volunteer their services to the uninsured or indigent.
H-210.991	The Education of Physicians in Home Care	It is the policy of the AMA that: (1) faculties of the schools of medicine be encouraged to teach the science and art of home care as part of the regular undergraduate curriculum; (2) graduate programs in the fields of family practice, general internal medicine, pediatrics, obstetrics, general surgery, orthopedics, physiatry, and psychiatry be encouraged to incorporate training in home care practice; (3) the concept of home care as part of the continuity of patient care, rather than as an alternative care mode, be promoted to physicians and other health care professionals; (4) assessment for home care be incorporated in all hospital discharge planning; (5) our AMA develop programs to increase physician awareness of and skill in the practice of home care; (6) our AMA foster physician participation (and itself be represented) at all present and	Retain; still relevant, with editorial revisions as shown to reflect the full (and current) names of the organizations in clause 6.

		future home care organizational planning initiatives (e.g., ~~JCAHO, ASTM, FDA~~, The Joint Commission, ASTM International, Food and Drug Administration, etc.); (7) our AMA encourage a leadership role for physicians as active team participants in home care issues such as quality standards, public policy, utilization, and reimbursement issues, etc.; and (8) our AMA recognize the responsibility of the physician who is involved in home care and recommend appropriate reimbursement for those health care services. (Joint CSA/CME Rep., A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-02; Modified: CSAPH Rep. 1, A-12)	
H-255.968	Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools	Our AMA: 1. supports the autonomy of medical schools to determine optimal tuition requirements for international students; 2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance; 3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); and 4. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, for four years of medical school. (CME Rep. 5, A-12)	Retain; still relevant.

H-255.987	Foreign Medical Graduates	1. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the US regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background. 2. Our AMA will: (a) continuously study challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce; and (b) lobby members of the US Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements. (Res. 56, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmation A-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 11, A-10; Appended: Res. 303, A-10; Reaffirmation A-11; Reaffirmation A-12)	Still relevant; append to H-255.988, "AMA Principles on International Medical Graduates," as these are central tenets related to IMGs that should be reflected in that overarching policy: Our AMA supports: … 23. Continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background. 24. Continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce. 25. Advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.
H-275.949	Discrimination Against Physicians Under Supervision of Their Medical Examining Board	1. Our AMA opposes the exclusion of otherwise capable physicians from employment, business opportunity, insurance coverage, specialty board certification or recertification, and other benefits, solely because the physician is either presently, or has been in the past, under the supervision of a medical licensing board in a program of rehabilitation or enrolled in a state-wide physician health program. 2. Our AMA will communicate Policy H-275.949 to all specialty boards and request that they reconsider their policy of exclusion where such a policy exists.	Rescind; superseded by D-405.984, "Confidentiality of Enrollment in Physicians (Professional) Health Programs:" 1. Our American Medical Association will work with other medical professional organizations, the Federation of State Medical Boards, the American Board of Medical Specialties, and the Federation of State Physician Health Programs, to seek and/or support rules and regulations or legislation to provide for confidentiality of fully compliant participants in physician (and similar) health programs or their recovery programs in responding to questions on medical practice or licensure applications. 2. Our AMA will work with The Joint Commission, national hospital

		(Sub. Res. 3, A-92; Reaffirmed: BOT Rep. 18, I-93; Reaffirmed: CME Rep. 2, A-05; Appended: Res. 925, I-11; Reaffirmed in lieu of Res. 412, A-12; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12)	associations, national health insurer organizations, and the Centers for Medicare and Medicaid Services to avoid questions on their applications that would jeopardize the confidentiality of applicants who are compliant with treatment within professional health programs and who do not constitute a current threat to the care of themselves or their patients. Also see H-275.978(6-9), "Medical Licensure:" (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine; (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;
H-275.953	The Grading Policy for Medical Licensure Examinations	1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection. 2. Our AMA adopts the following policy on NBME or	Retain; still relevant, with the exception of clause 3, which was fulfilled through Council on Medical Education Report 5-I-19, "The Transition from Undergraduate Medical Education to Graduate Medical Education."

		USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students. ~~3. Our AMA will co-convene the appropriate stakeholders to study possible mechanisms for transitioning scoring of the USMLE and COMLEX exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE and COMLEX scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates.~~ ~~3~~4. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate	

		Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system. 4~~5~~. Our AMA will work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination of the United States Level 1 scores and students who received Pass/Fail scores. (CME Rep. G, I-90; Reaffirmed by Res. 310, A-98; Reaffirmed: CME Rep. 3, A-04; Reaffirmed: CME Rep. 2, A-14; Appended: Res. 309, A-17; Modified: Res. 318, A-18; Appended: Res. 955, I-18; Appended: Res. 301, I-21)	
H-275.956	Demonstration of Clinical Competence	It is the policy of the AMA to (1) support continued efforts to develop and validate methods for assessment of clinical skills; (2) continue its participation in the development and testing of methods for clinical skills assessment; and (3) recognize that clinical skills assessment is best performed using a rigorous and consistent examination administered by medical schools and should not be used for licensure of graduates of Liaison Committee on Medical Education (LCME)- and American Osteopathic Association (AOA)-accredited medical schools or of Educational Commission for Foreign Medical Graduates	Rescind; superseded by D-295.988, "Clinical Skills Assessment During Medical School:" 1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills. 2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination

		(ECFMG)-certified physicians. (CME Rep. E, A-90; Reaffirmed: CME Rep. 5, A-99; Modified: Sub. Res. 821, I-02; Modified: CME Rep. 1, I-03; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 313, A-12)	(USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination. 3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency. 4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills. 5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed. 6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into

			the areas of unsatisfactory performance on the examination. 7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary. Also superseded by D-275.950, "Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association:" Our AMA: (1) will take immediate, expedited action to encourage the National Board of Medical Examiners (NBME), Federation of State Medical Boards (FSMB), and National Board of Osteopathic Medical Examiners (NBOME) to eliminate centralized clinical skills examinations used as a part of state licensure, including the USMLE Step 2 Clinical Skills Exam and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2 - Performance Evaluation Exam; (2) in collaboration with the Educational Commission for Foreign Medical Graduates (ECFMG), will advocate for an equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills competency; (3) strongly encourages all state delegations in the AMA House of Delegates and other interested member organizations of the AMA to engage their respective state medical licensing boards, the Federation of State Medical Boards, their medical schools and other interested credentialling bodies to encourage the elimination of these centralized, costly and low-value exams; and (4) will advocate that any replacement examination mechanisms be instituted immediately in lieu of resuming existing USMLE Step 2-CS and COMLEX Level 2-PE examinations when the COVID-19 restrictions subside.
D-275.974	Depression and Physician Licensure	Our AMA will (1) recommend that physicians who have major depression and seek treatment not have their	Rescind; superseded by H-275.970, "Licensure Confidentiality," which reads:

		medical licenses and credentials routinely challenged but instead have decisions about their licensure and credentialing and recredentialing be based on professional performance; and (2) make this resolution known to the various state medical licensing boards and to hospitals and health plans involved in physician credentialing and recredentialing. (Res. 319, A-05; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12)	1. The AMA (a) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (b) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (c) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (d) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (e) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is suffering from any condition that currently impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger. 2. Our AMA will encourage those state medical boards that wish to retain questions about the health of applicants on medical licensing applications to use the language recommended by the Federation of State Medical Boards that reads, "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)."
D-275.992	Unified Medical License Application	Our AMA will request the Federation of State Medical Boards to examine the issue of a standardized medical licensure application form for those data elements that are common to all medical licensure applications. (Res. 308, I-01; Reaffirmed:	Rescind; this directive has been accomplished. Currently, 28 licensing jurisdictions use the Uniform Application for Physician State Licensure from the Federation of State Medical Boards.

		CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-12)	
D-295.934	Encouragement of Interprofessional Education Among Health Care Professions Students	1. Our AMA~~: (A)~~ recognizes that interprofessional education and partnerships are a priority of the American medical education system~~; and (B) will explore the feasibility of the implementation of Liaison Committee on Medical Education and American Osteopathic Association accreditation standards requiring interprofessional training in medical schools~~. 2. Our AMA supports the concept that medical education should prepare students for practice in physician-led interprofessional teams. 3. Our AMA will encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners. 4. ~~Our AMA will encourage the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to facilitate the incorporation of physician-led interprofessional education into the educational programs for medical students and residents in ways that support high quality medical education and patient care.~~ ~~5.~~ Our AMA will encourage the development of skills for interprofessional education that are applicable to and appropriate for each group of learners. (Res. 308, A-08; Appended: CME Rep. 1, I-12)	Retain in part, with edits to clauses 1 and 4, as these directives have been accomplished.
D-295.942	Patient Safety Curricula in Undergraduate Medical Education	1. Our AMA will explore the feasibility of asking the Liaison Committee on Medical Education to encourage the discussion of basic patient	Rescind; superseded by H-295.864, "Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians."

		safety and quality improvement issues in medical school curricula. 2. Our AMA will encourage the Liaison Committee on Medical Education to include patient safety and quality of patient care curriculum within the core competencies of medical education in order to instill these fundamental skills in all undergraduate medial students. (Res. 801, I-07; Appended: Res. 320, A-12)	Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes.
D-295.964	Pharmaceutical Federal Regulations -- Protecting Resident Interests	Our AMA shall continue to evaluate and oppose, as appropriate, federal regulations on the pharmaceutical industry that would curtail educational and/or research opportunities open to residents and fellows that are in compliance with current AMA ethical guidelines. (Res. 921, I-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)	Retain; still relevant.
D-295.966	Pain Management Standards and Performance Measures	Our AMA, through the Council on Medical Education, shall continue to work with relevant medical specialty organizations to	Rescind; superseded by D-160.981 (1), "Promotion of Better Pain Care:"

		improve education in pain management in medical schools, residency programs, and continuing medical education programs. (CSA Rep. 4, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)	1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic. Also superseded by D-120.985(3), "Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone:" 3. Our AMA will work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for Graduate Medical Education, and other interested professional organizations to develop opioid education resources for medical students, physicians in training, and practicing physicians.
D-295.970	HIV Postexposure Prophylaxis for Medical Students During Electives Abroad	Our AMA: (1) recommends that US medical schools ensure that medical students who engage in clinical rotations abroad have immediate access to HIV postexposure prophylaxis; and (2) encourages medical schools to provide information to medical students regarding the potential health risks of completing a medical rotation abroad, and on the appropriate precautions to take to minimize such risks. (Res. 303, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)	Retain; still relevant, with minor edit as shown so that the policy content matches the title.

D-295.972	Standardized Advanced Cardiac Life Support (ACLS) Training for Medical Students	Our AMA shall: (1) encourage standardized Advanced Cardiac Life Support (ACLS) training for medical students prior to clinical clerkships; and (2) strongly encourage medical schools to fund ACLS training for medical students. (Res. 314, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)	Retain by rescission and appending to related Policy H-300.945, "Proficiency of Physicians in Basic and Advanced Cardiac Life Support," to read as follows: Our AMA: (1) believes that all licensed physicians should become proficient in basic CPR and in advanced cardiac life support commensurate with their responsibilities in critical care areas; (2) recommends to state and county medical associations that programs be undertaken to make the entire physician population, regardless of specialty or subspecialty interests, proficient in basic CPR; and (3) encourages training of cardiopulmonary resuscitation and basic life support be funded by medical schools and provided to first-year medical students, preferably during the first term or prior to clinical clerkships.
H-295.876	Equal Fees for Osteopathic and Allopathic Medical Students	1. Our AMA, in collaboration with the American Osteopathic Association, discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training. 2. Our AMA encourages equitable access to and equitable fees for clinical electives for allopathic and osteopathic medical students. ~~3. Our AMA will work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations, and generate a report with the findings by the 2020 Interim Meeting.~~ 34. Our AMA: (a) encourages the Association of American Medical Colleges to request that its member institutions promote equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable	Retain; still relevant, with the exception of clause 3, which has been fulfilled through Council on Medical Education Report 5-N-21, "Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations."

		fees to visiting allopathic and osteopathic medical students; and (b) encourages the Accreditation Council for Graduate Medical Education to require its accredited programs to work with their respective affiliated institutions to ensure equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students. (Res. 809, I-05; Appended: CME Rep. 6, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 303, I-19; Modified: CME Rep. 5, I-21)	
H-295.882	Proposed Consolidation of Liaison Committee on Medical Education	(1) Our AMA reaffirms its ongoing commitment to excellence in medical education and its continuing responsibility for accreditation of undergraduate medical education. (2). Our AMA supports a formal recognition of the organizational relationships among the AMA, the AAMC, and the LCME through a memorandum of understanding. (3) Consistent with United States Department of Education regulations and its historic role, the LCME should remain the final decision-making authority over accreditation matters, decisions, and policies for undergraduate medical education leading to the MD degree. (4) The LCME will have final decision-making authority regarding the establishment, adoption and amendment of accreditation standards, through a defined process that allows the sponsors an opportunity to review, comment, and recommend changes to, and refer back for further consideration, new or	Rescind; this policy was accomplished in 2012, implemented in 2013, and remains in effect through the LCME Council and other activities of the AMA, AAMC, and LCME.

		amended standards proposed by the LCME. (5) A new entity will be formed to support communications, flexibility and planning among the AMA, the AAMC and the LCME on medical school accreditation, with membership, authority and additional parameters to be defined within the new memorandum of understanding. (6) The AMA Council on Medical Education will be the entity within the AMA to determine policy relating to the organization or structure of the LCME. (CME Rep. 7, A-03; Modified and Appended: BOT Rep. 16, A-12)	
D-300.996	Voluntary Continuing Education for Physicians in Pain Management	Our AMA will encourage appropriate organizations to support voluntary continuing education for physicians based on effective guidelines in pain management. (Res. 308, A-01; Modified: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-1)	Rescind; superseded by D-160.981(1), "Promotion of Better Pain Care:" 1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic. Also superseded by D-120.985(3), "Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone:"

			3. Our AMA will work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for Graduate Medical Education, and other interested professional organizations to develop opioid education resources for medical students, physicians in training, and practicing physicians.
D-310.974	Policy Suggestions to Improve the National Resident Matching Program	Our AMA will: (1) request that the National Resident Matching Program review the basis for the extra charge for including over 15 programs on a primary rank order list and consider modifying the fee structure to minimize such charges; (2) work with the NRMP to increase awareness among applicants of the existing NRMP waiver and violations review policies to assure their most effective implementation; (3) request that the NRMP continue to explore measures to maximize the availability of information for unmatched applicants and unfilled programs including the feasibility of creating a dynamic list of unmatched applicants; (4) ask the National Resident Matching Program (NRMP) to publish data regarding waivers and violations with subsequent	Rescind as a number of aspects of this directive have been accomplished, and incorporate the remaining relevant and timely segments into D-310.977 (1) and (4), "National Resident Matching Program Reform," as shown below. Clause 1: Rescind; this runs counter to the current approach of encouraging medical students to be judicious in the number of match applications, as this increases the burden on residency program personnel and does not appreciably help the applicant, after a certain threshold of program applications is reached. Clause 2: Retain through insertion of relevant language into Clause 1 of D-310.977, as shown below. Clause 3: Rescind; this request is reflected in the NRMP's Supplemental Offer and Acceptance Program (SOAP). Clause 4: Rescind; the NRMP has published two articles in this regard, on applicant non-compliance and program non-compliance, respectively. Clause 5: Rescind; reflected in NRMP policy on match violations, section 6.E.b.iii, which states that sanctions for a confirmed violation by an applicant include "being barred for one year from accepting an offer of a position or a new training year, regardless of the start date (or renewing a training contract for a position at a different level or for a subsequent year), in any residency or fellowship training program sponsored by a Match-participating institution and/or starting a position or a new

		consequences for both programs and applicants while maintaining the integrity of the match and protecting the identities of both programs and participants; (5) advocate that the words "residency training" in section 8.2.10 of the NRMP Match agreement be added to the second sentence so that it reads, "The applicant also may be barred from accepting or starting a position in any residency training program sponsored by a match-participating institution that would commence training within one year from the date of issuance of the Final Report" and specifically state that NRMP cannot prevent an applicant from maintaining his or her education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs; and (6) work with the Educational Commission for Foreign Medical Graduates, Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and other graduate medical education stakeholders to encourage the NRMP to make the conditions of the Match agreement more transparent while assuring the confidentiality of the match and to use a thorough process in declaring that a violation has occurred.	training year in any program sponsored by a Match-participating institution if training would commence within one year from the date of issuance of the Final Report." Clause 6: Retain through insertion of relevant language into Clause 4 of D-310.977, as shown below. The phrase "and using a thorough process in declaring that a violation has occurred" is not included in the edits below, as it is reflected in the NRMP policy noted above on match violations. Also, note editorial change below to the end of Clause 8 (adding an "s" to "applicant"). Our AMA: (1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies; (2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match; (3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match; (4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match; (5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians; (6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process; (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary

		(CME Rep. 15, A-06; Appended: Res. 918, I-11; Appended: CME Rep. 12, A-12)	match or scramble process to create more standardized rules for all candidates including application timelines and requirements; (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants; (9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas; (10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers; (11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO

			degree who do not enter residency programs; (12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs; (13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program; (14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions; (15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match; (16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; (17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine; and (18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency.

H-310.909	ACGME Residency Program Entry Requirements	Our AMA supports entry into Accreditation Council on Graduate Medical Education (ACGME) accredited residency and fellowship programs from either ACGME-accredited programs or American Osteopathic Association-accredited programs. (Res. 920, I-12)	Rescind; the number of formerly AOA-accredited but not ACGME-accredited programs is small, and none are accepting new residents. Therefore, this policy is not needed after the unification of graduate medical education residency program accreditation through the ACGME's Single Accreditation System.
H-350.981	AMA Support of American Indian Health Career Opportunities	AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded. (2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals. (3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population. (4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and	Retain; still relevant.

		continued contributions in planning and program operations. (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12)	
H-460.982	Availability of Professionals for Research	(1) In its determination of personnel and training needs, major public and private research foundations, including the Institute of Medicine of the National Academy of Sciences, should consider the future research opportunities in the biomedical sciences as well as the marketplace demand for new researchers. (2) The number of physicians in research training programs should be increased by expanding research opportunities during medical school, through the use of short-term training grants and through the establishment of a cooperative network of research clerkships for students attending less research-intensive schools. Participation in research training programs should be increased by providing financial incentives for research centers, academic physicians, and medical students. (3) The current annual production of PhDs trained in the biomedical sciences should be maintained. (4) The numbers of nurses, dentists, and other health professionals in research training programs should be increased. (5) Members of the industrial community should increase their philanthropic financial support to the nation's biomedical research enterprise. Concentration of support on the training of young investigators should be a major thrust of increased funding. The pharmaceutical and medical device industries should increase substantially their intramural and	Rescind; this policy, first adopted in 1987, is superseded by two more recently amended policies. H-460.930, "Importance of Clinical Research" (1) Given the profound importance of clinical research as the transition between basic science discoveries and standard medical practice of the future, the AMA will a) be an advocate for clinical research; and b) promote the importance of this science and of well-trained researchers to conduct it. (2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense. (3) The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research. (4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health

		extramural commitments to meeting postdoctoral training needs. A system of matching grants should be encouraged in which private industry would supplement the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration sponsored Career Development Awards, the National Research Service Awards and other sources of support. (6) Philanthropic foundations and voluntary health agencies should continue their work in the area of training and funding new investigators. Private foundations and other private organizations should increase their funding for clinical research faculty positions. (7) The National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration should modify the renewal grant application system by lengthening the funding period for grants that have received high priority scores through peer review. (8) The support of clinical research faculty from the National Institutes of Health Biomedical Research Support Grants (institutional grants) should be increased from its current one percent. (9) The academic medical center, which provides the multidisciplinary research environment for the basic and clinical research faculty, should be regarded as a vital medical resource and be assured adequate funding in recognition of the research costs incurred. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSA Rep. 13, I-99; Reaffirmed: CME Rep. 4, I-08; Modified: Res. 305, A-12; Modified: CME Rep. 2, A-12)	centers can actively involve practicing physicians in clinical research. (5) Our AMA encourages and supports development of community and practice-based clinical research networks. (CSA Rep. 2, I-96; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: CME Rep. 4, I-08; Modified: CSAPH Rep. 01, A-18) H-460.971, "Support for Training of Biomedical Scientists and Health Care Researchers" Our AMA: (1) continues its strong support for the Medical Scientists Training Program's stated mission goals; (2) supports taking immediate steps to enhance the continuation and adequate funding for stipends in federal research training programs in the biomedical sciences and health care research, including training of combined MD and PhD, biomedical PhD, and post-doctoral (post MD and post PhD) research trainees; (3) supports monitoring federal funding levels in this area and being prepared to provide testimony in support of these and other programs to enhance the training of biomedical scientists and health care research; (4) supports a comprehensive strategy to increase the number of physician-scientists by: (a) emphasizing the importance of biomedical research for the health of our population; (b) supporting the need for career opportunities in biomedical research early during medical school and in residency training; (c) advocating National Institutes of Health support for the career development of physician-scientists; and (d) encouraging academic medical institutions to develop faculty paths supportive of successful careers in medical research; and (5) supports strategies for federal government-sponsored programs, including reduction of education-

			acquired debt, to encourage training of physician-scientists for biomedical research. (Res. 93, I-88; Reaffirmed: Sunset Report, I-98; Amended: Sub. Res. 302, I-99; Appended: Res. 515 and Reaffirmation A-00; Reaffirmed: CME Rep. 14, A-09; Reaffirmed: CSAPH Rep. 01, A-19)
H-480.950	Diagnostic Ultrasound Utilization and Education	Our AMA affirms that ultrasound imaging is a safe, effective, and efficient tool when utilized by, or under the direction of, appropriately trained physicians and supports the educational efforts and widespread integration of ultrasound throughout the continuum of medical education. (Res. 507, A-12)	Retain; still relevant.
D-630.972	AMA Race/ Ethnicity Data	Our American Medical Association 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. (BOT Rep. 24, I-06; Modified: CCB/CLRPD Rep. 3, A-12)	Retain; still relevant.

REPORT 02 OF THE COUNCIL ON MEDICAL EDUCATION (A-22)
An Update on Continuing Board Certification
(Reference Committee C)

EXECUTIVE SUMMARY

The Council on Medical Education has monitored continuing board certification (CBC), formerly referred to as maintenance of certification (MOC), during the last year. This annual report, per American Medical Association (AMA) Policy D-275.954, "Continuing Board Certification," provides an update on some of the changes that have occurred as a result of collaboration among multiple stakeholder groups with active input from the AMA to improve the CBC process. Due to the impact of the COVID-19 pandemic and reprioritization of business put forth to the AMA House of Delegates (HOD), submission of this Council report was moved to the 2022 Annual Meeting.

The Continuing Board Certification: Vision for the Future Commission was established in 2018 by the American Board of Medical Specialties (ABMS) and charged with reviewing continuing certification within the current context of the medical profession. In 2019, the Commission completed its final report, which contained 14 recommendations intended to modernize CBC, with input from the AMA Council on Medical Education ("Council"). The ABMS and its member boards, in collaboration with professional organizations and other stakeholders, agreed upon and prioritized these recommendations and developed strategies to implement them. A summary of these strategies was provided in the previous annual Council report.[1] In April 2021, the ABMS released Draft Standards for Continuing Certification. These Standards reflect foundational changes to the manner in which ABMS and its member boards deliver on their mission, bringing value to both the profession and the public at large. A Call for Comments period from April-July 2021 allowed for stakeholder feedback. The ABMS Board of Directors reviewed the feedback at their October 2021 meeting and released the final standards shortly thereafter.

All ABMS member boards now offer alternatives to the historical high-stakes, 10-year examination or are administering longitudinal assessment pilots, enabling delivery of assessments that promote continual learning and are less burdensome. Appendix A in this report provides updates on these models. The ABMS member boards continue to expand the range of acceptable activities that meet the Improvement in Medical Practice (IMP) requirements in response to physician concerns about the relevance, cost, and time associated with fulfilling the IMP requirements. Appendix A also includes an update of these initiatives.

Given the consequences of the COVID-19 pandemic, several boards offered temporary changes to continuing as well as initial certification requirements, as listed in Appendix B.

The Council is committed to ensuring that CBC supports physicians' ongoing learning and practice improvement and remains actively engaged in the implementation of the Commission's recommendations and the development and release of Standards for Continuing Certification.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-A-22

Subject: An Update on Continuing Board Certification

Presented by: Niranjan V. Rao, MD, Chair

Referred to: Reference Committee C

Policy D-275.954(1), "Continuing Board Certification," asks that the American Medical Association (AMA) "continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a yearly report to the HOD regarding the CBC process."

Council on Medical Education Report 1, "An Update on Continuing Board Certification," adopted at the Special November 2020 Meeting, recommended that our AMA, "through its Council on Medical Education, continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development of new, integrated standards for continuing certification programs by 2020 that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency." This recommendation was appended to Policy D-275.954, becoming the 38th clause.

This report is submitted for the information of the House of Delegates in response to these policies.

BACKGROUND

The years 2020-2021 saw the emergence and spread of the novel coronavirus (COVID-19), first identified outside of the U.S. in late 2019 and quickly evolving into a global pandemic. Due to the impact of COVID-19, the traditional in-person Annual and Interim Meetings of the AMA House of Delegates (HOD) were not feasible. Special Meetings of the HOD were conducted in a virtual format in June and November 2020 and 2021. The streamlined June 2020 Meeting contained only essential business of the HOD; therefore, it did not address resolutions or reports which had been originally intended for that Meeting. As such, this annual report was moved to the November 2020 Meeting. This change reset the annual clock for the report, which is now submitted each year to the Interim Meeting. However, reports were again streamlined for the November 2021 meeting, which resulted in this report being deferred to Annual 2022.

The ramifications of COVID-19 were also felt by the ABMS and its member boards. Various meetings and conferences scheduled in 2020-2021 were cancelled, delayed, or moved to a virtual format. Many initiatives and programs were altered or put on hold. The ABMS released several statements throughout 2020 and 2021 to provide guidance to member boards and physicians. This report provides an overview of the CBC landscape and advancements during this unsettling period despite the challenges posed by a public health crisis.

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CONTINUING BOARD CERTIFICATION: VISION FOR THE FUTURE COMMISSION

In 2018, the Continuing Board Certification: Vision for the Future Commission, an independent body of 27 individuals representing diverse stakeholders, was established by the ABMS and charged with reviewing continuing certification within the current context of the medical profession. Later that year, the AMA Council on Medical Education ("Council") provided comments to strengthen the draft recommendations of the Commission. The Commission's final report, released in 2019, contained research, testimony, and public feedback from stakeholders throughout the member boards and health care communities. The report comprised of 14 recommendations intended to modernize CBC so that it is meaningful, contemporary, and a relevant professional development activity for diplomates who are striving to be up to date in their specialty of medicine. The ABMS and its member boards, in collaboration with professional organizations and other stakeholders, agreed and prioritized these recommendations and developed strategies and task forces to implement them (as described in the last report, CME 1-N-20).[1] The Commission's report included a commitment by the ABMS to develop new, integrated Standards for continuing certification programs by 2020. The final set of recommendations marked the end of the Commission's work. Due to COVID-19, the release of these draft Standards was delayed to 2021.

Updates on ABMS Task Forces

The "Achieving the Vision" task forces continued their work, with many of the physician volunteer members making an extraordinary effort to actively contribute, while also meeting the demands of being on the front line battling COVID-19. On May 1, 2020, the Chairs of the Improving Health and Health Care, Professionalism, Remediation, and Information and Data Sharing Task Forces met virtually with the Council to share updates on their progress and received feedback from Council members to help inform and guide their work.

The Improving Health and Health Care (IHHC) Task Force, formerly the Advancing Practice Task Force, was asked to engage specialty societies, the continuing medical education/continuing professional development community, and other expert stakeholders to identify practice environment changes necessary to support learning and improvement activities to produce data-driven advances in clinical practice. The task force promoted a "wide door" approach to a broader range of potential improvement options for diplomates, recommending that the member boards support improvement at any level—personal, team, system, or community—that is relevant to any role in which a diplomate serves. The task force emphasized the use of clear, non-technical language in the belief that many diplomates are alienated by and unfamiliar with tools of quality improvement. Recognizing that this unfamiliarity may be in part what keeps diplomates disengaged, the task force encouraged further learning about health systems science, improvement science, and safety science, and incorporating knowledge of those methods into member board assessment programs. Through its work, the task force heard about successful strategies that some member boards use and about the impressive array of tools and services available from the specialty societies, particularly with respect to data resources, quality tools, and coaching/practice facilitation services. Members discussed promoting teamwork and team-based improvement and leveraging the sponsors of the ABMS Portfolio Program to create locally available, practice-relevant opportunities aligned with institutional quality priorities. To support small and independent practices, the group was impressed by the AMA's STEPS Forward™ resources, which help physicians make their practices more efficient, increase practice satisfaction and reduce burnout. The task force recommended partnering with the specialty and medical societies to make tools and resources available to diplomates. It also examined how improvement methods could be used by diplomates to work on important priorities, such as equity and professionalism, and how

they could support related learning, assessment, and improvement. Importantly, the task force has recommended that ABMS transform ongoing efforts to support improvement work into a "Community of Learning," focused on a strategic approach incorporating internal and external stakeholders, expertise, and resources.

The Information and Data Sharing Task Force (IDSTF) was assigned the task of examining the development of processes and infrastructure to facilitate research and data collaboration between member boards and key stakeholders to inform future continuing certification assessments, requirements, and standards that will facilitate the prioritization of specialty learning and improvement goals. The goals of these collaborations include studying the impact of continuing certification on diplomate professional development, changes in diplomate practice, and changes in patient outcomes. Initially, the IDSTF focused on identifying data that member boards collect currently on their diplomates as well as data that are most important to support collaboration with other organizations. The group's milestones emphasized the importance of identifying necessary enhancements to the existing ABMS Boards' data warehouse structure in support of potential research-based data needs. Transparency and governance of data usage remain critical considerations, and the task force believes that the ABMS Boards Community must continue to ensure the privacy of diplomates as it engages in research evaluating the value of continuing certification. The task force also discussed the timely issue of the collection of data related to diversity, equity, and inclusion (DEI) within the ABMS Boards community. The group recognized the importance of DEI data sets and their essential role in certification research going forward.

The Professionalism Task Force was established to address the recommendation of the Commission calling for the ABMS and ABMS member boards to seek input from other stakeholder organizations to develop approaches to evaluate professionalism and professional standing while ensuring due process for the diplomate when questions of professionalism arise. The task force emphasized the importance of promoting positive professionalism through policies and programs. It also supported behavioral approaches to enhancing professionalism by encouraging formative assessment, learning, and improvement focused on interpersonal and social relationship skills vital to good health care. Task force members felt that diplomates would benefit from formative feedback on workplace performance accompanied by learning and improvement activities and encouraged the ABMS to work collaboratively with specialty societies to develop high-quality assessment tools and resources that can be used to support the development of professionalism skills. The task force also encouraged the ABMS to advocate for professional values, including issues of health equity and scientific integrity.

The Remediation Task Force was tasked with defining aspects of and suggesting a set of pathways for longitudinal assessment programs (LAP) and non-LAP for remediation of gaps prior to certificate loss, balancing specialty-specific practice differences with the avoidance of non-value-added variation in processes. In addition, this task force was asked to differentiate between pathways for re-entry and regaining certification after diplomate loss of certificate, based on the reason for certificate revocation. To inform and facilitate its work, the group established a peer-reviewed literature resource center of scholarly work on diplomate remediation and assessment research and established the development of a central repository of remediation programs that can effectively serve diplomates and improve the delivery of quality patient care.

The Standards Task Force was tasked with developing new continuing certification standards consistent with the Commission's recommendations, with appropriate input from stakeholders (including practicing physicians and diplomates) that would be implemented by the ABMS member boards. The final set of new standards was presented to and adopted by the ABMS Board of Directors in October 2021. The new Standards represent the culmination of three years of

consultation with diplomates, professional and state medical societies, consumers, and other public stakeholders from across the health care spectrum to reconceive the way specialty physician recertification is conducted. They have been designed to guide the ABMS member boards in establishing continuing certification programs that help diplomates stay current in their specialty while providing hospitals, health systems, patients, and communities with a credential upon which they can continue to rely and depend.

The development of the new Standards was inclusive and transparent by design. Nearly 100 volunteers were involved in the process, representing important stakeholder groups, including professional and state medical societies, individual practicing diplomates, member boards, and public constituents such as credentialers and health care consumer advocates. Additionally, thousands of individuals and organizations provided feedback on the draft Standards during an 80-day public comment period. The feedback collected was highly valued, and each draft Standard was revised in some manner to address the comments received. This resulted in a final set of Standards that meets the needs of the stakeholders who possess, use, or rely upon the board certification credential as an indicator of a diplomate's skills, knowledge, judgment, and professionalism. The new Standards reinforce the transition to innovative assessment programs that support and direct learning. These new assessment models represent an intentional shift from conventional high-stakes exams every 10 years to frequent, flexible, online testing that offers immediate feedback and directs participants to resources for further study. The new systems support learning and retention and complement the continuing education that that all physicians undertake to improve their skills. The new Standards also support greater opportunities for recognition of quality and safety improvement activities in which diplomates are engaged and provide member boards the flexibility to address specialty-specific requirements. A phased-in transition will be used to implement the standards, and member boards will continue to assess, update, and modify their programs based on diplomate and public feedback.

Standards for Continuing Certification

The Draft Standards for Continuing Certification were intended to address the Commission's recommendations for consistency yet flexibility in knowledge assessment and advancing practice and guidance for feedback. The Standards were developed after a year of deliberation with key stakeholders in response to the recommendations of the Vision Commission as well as of the wider stakeholder community. The ABMS had been prepared to release a Call for Comments on the Draft Standards in early December 2020 in accordance with the timeframes established in the Commission's final report. However, the surge in new COVID-19 cases placed an additional burden on the already stressed health care system, which prompted the ABMS to postpone the opening of the public comment period to April-July 2021. The ABMS Board of Directors reviewed the feedback at their October 2021 meeting, and the new Standards were released on November 1, 2021.

These 19 Standards were structured to support and provide diplomates with the tools they need to stay current in medical knowledge, prepare them to address emerging medical and public health issues, and help them identify and address opportunities for practice improvement within the systems in which they work—all in a manner that enhances relevance and reduces burden. They have been organized into the following groups: General Standards, Professional Standing, Lifelong Learning, and Improvement in Health and Health Care. Each member board must meet each requirement in a manner consistent with the spirit of the Standards and in a fashion consistent with its specialty. Each Standard has associated commentary which provides rationale and context and addresses important considerations. The Standards read as follows:

#	NEW STANDARD	COMMENTARY
	General Standards	
1	**Program Goals:** Member boards must define goals for their continuing certification program that address the overarching themes in the Introduction* and each of the subsequent standards in this document.	Program elements should be designed to achieve the goals of the program, highlight the boards' unique role as an assessment organization, lessen diplomate burden, and support diplomates in their professional obligation to keep up to date with advances in medical knowledge and continually improve themselves, their colleagues, and the systems in which they work. The goals and components of continuing certification programs should be clearly communicated and available on member board websites for stakeholders, which includes the public, diplomates, and credentialers.
2	**Requirements for Continuing Certification:** Member boards must define the requirements and deadlines for each component of their integrated continuing certification program.	Both participation and performance requirements for each component must be clearly specified along with the intervals at which they must be completed. Any decision on the certificate status of a diplomate by a member board must be based on each component of their integrated continuing certification program. Member boards may make allowances for diplomates with extenuating circumstances who cannot complete requirements to stay certified according to established timelines. Appropriate procedures to ensure due process regarding member board decisions must be in place and clearly communicated to diplomates as part of diplomate engagement. Member boards should have a process to verify attestation for participation standards.
3	**Assessment of Certification Status:** Member boards must determine at intervals no longer than five years whether a diplomate is meeting continuing certification requirements to retain each certificate.	Assessment of certification status on a frequent interval provides the public and credentialers trusted information about the diplomate; therefore, member boards may make certification decisions on a more frequent interval than five years. Policies that specify the requirements for certification and the relevant periodicity will be established by each member board. These policies require a decision to determine a diplomate's certificate status (e.g., certified, not certified) at the established interval. The components utilized to make a certification decision in the board-determined

		interval may vary (e.g., knowledge assessment, case logs, peer review, improving health and health care activity). Member boards may have some components of their continuing certification process that extend beyond five years.
4	**Transparent Display of Certification History:** Member boards must publicly display and clearly report a diplomate's certification status and certification history for each certificate held. Member boards must change a diplomate's certificate(s) status if any requirements (either a performance or participation requirement) in their continuing certification program are not met. Changes in the status of a certificate must be publicly displayed, including any disciplinary status. Member boards must use common categories for reporting the status of certificates, with such categories being defined, used, and publicly displayed in the same way.	Member boards have an obligation to the medical community and the public to display on their respective websites and/or the ABMS Certification Matters website, the certification status and history for each diplomate including the date of initial certification, whether the diplomate is certified, and whether the diplomate is participating in continuing certification.
5	**Opportunities to Address Performance or Participation Deficits:** Member boards must provide diplomates with opportunities to address performance or participation deficits prior to the loss of a certificate. Fair and sufficient warning, determined by each member board, must be communicated that a certificate might be at risk.	Diplomates should receive early notice about the need to complete any component of the continuing certification program. Diplomates at risk for not meeting a performance standard should be notified of their deficit along with information about approaches to meet the requirements. Member boards should collaborate with specialty societies and other organizations to encourage the development of resources to address performance deficits. The timeline to address deficits should not extend the time a diplomate has to complete requirements (i.e., deficits must be addressed within the cycle they are due). If a diplomate chooses not to address their deficits or is unsuccessful in doing so, the diplomate should be notified of the potential for the loss of certification.
6	**Regaining Certification:** Member boards must define a process for regaining certification if the loss of certification resulted from not meeting a participation or performance standard.	A pathway should be available for physicians and medical specialists to regain certification following loss of certification after a lack of participation in a continuing certification program or not meeting the performance standard.
7	**Program Evaluation:** Member boards must continually evaluate and improve	It is crucial for member boards to evaluate their continuing certification program on an

	their continuing certification program using appropriate data that include feedback from diplomates and other stakeholders.	ongoing basis using a variety of metrics to guide enhancements to their program. Aspects of program evaluation should include assessing diplomate experience, the value of the program to diplomates, and whether diplomates are meeting the member board's objectives. Feedback from other certification stakeholders — professional societies, credentialers, hospitals and health systems, patients, and the public — should also be considered.
8	**Holders of Multiple Certificates:** Member boards must streamline requirements for diplomates who hold multiple certificates, to minimize duplication of effort and cost.	Diplomates who hold multiple specialty and/or subspecialty certificates from one or more member boards could have duplicative requirements to maintain all certificates. member boards should avoid redundancy of requirements of programs for their diplomates maintaining multiple certificates from their board (e.g., Lifelong Learning credit for participation in longitudinal assessment and improving health and health care credit for quality improvement efforts). Similar processes should be incorporated to offer reciprocity of credit for diplomates with multiple certificates held across member boards (e.g., Lifelong Learning credit for participation in longitudinal assessment and improving health and health care credit for quality improvement efforts).
9	**Diplomates Holding Non-time-limited Certificate:** Member boards must have a process by which non-time-limited certificate holders can participate in continuing certification without jeopardizing their certification status.	Member boards must have a process for diplomates with non-time-limited certificates to apply for and participate in their continuing certification programs. Certificates for non-time-limited certificate holders should not be at risk for failure to meet continuing certification requirements if the diplomate participates in continuing certification; however, member board professional standing and conduct standards must be upheld by all certificate holders in order to remain certified.
	Professional Standing and Conduct	
10	**Review of Professional Standing**: Primary Source Verification of unrestricted licensure must occur annually. In addition, member boards must have a mechanism to identify and review information regarding licensure in every state in which the diplomate holds a medical license. Any actions by other	Credentialers and the public rely on ABMS and its member boards to ensure that diplomates meet high standards of professionalism. Member boards rely on state medical licensing boards for primary evidence that diplomates maintain good standards of professional conduct and expect medical licenses held by diplomates to be unrestricted.

	authorities that signal a violation of the member board's professionalism policies that become known by a board must also be reviewed.	On a timely basis, member boards are expected to review available information, including restrictions forwarded to the member board, and take appropriate action to protect patient safety and the trustworthiness of ABMS board certification. Member boards are expected to distinguish between material actions and actions that are administrative rule violations that do not threaten patient care or that are being appropriately monitored and resolved by the regulatory authority. • To ensure diplomates are in good standing with their licensing board(s), ABMS will facilitate Primary Source Verification of unrestricted licensure with a seamless and efficient mechanism through which member boards can easily identify restrictions on a diplomate's medical license. • Mechanisms such as the ABMS Disciplinary Action Notification Service reports may assist member boards in continually monitoring any actions taking place between annual Primary Source Verification of licensure. • Member boards may choose to use additional methods to evaluate professional standing. • Member boards must effectively communicate the expectations and process for diplomate self-reporting of any changes in professional standing and the implications for failing to do so.
11	**Responding to Issues Related to Professional Standing and Conduct:** Member boards must have policies on professional standing and conduct that define the process for reviewing and taking action on the information that reflects a violation of professional norms. Policies should be communicated to diplomates and available on member board websites.	Member board policies on professional standing and conduct are to be made readily accessible to diplomates and the public. These policies ensure that: • Material actions that may imperil a diplomate's certificate status are clearly defined (e.g., disciplinary actions against a license, criminal convictions, incidents of sexual misconduct); • The facts and context of each action are considered before making any change in a diplomate's certification status; • Appropriate procedures to ensure due process are in place and clearly articulated to diplomates; and

		• There is a clearly outlined process for diplomates to regain a revoked certificate if they are eligible to do so. When disciplinary actions are reported, member boards should review each instance in which an action has been taken against a diplomate's license (e.g., revoked, suspended, surrendered, or had limitations placed) to determine if there has been a material breach of professional norms that may threaten patient safety or undermine trust in the profession and the trustworthiness of certification. Actions against a medical license should not automatically lead to actions against a certificate without reviewing the individual facts and circumstances of the situation. A change in certificate status should occur when the diplomate poses a risk to patients or has engaged in conduct that could undermine the public's trust in the diplomate, profession, and/or certification. This standard for professional standing and conduct means that the loss of a certificate can result from issues that fall short of a licensure action. Conversely, some licensure actions may not warrant a change in certificate status. For example, there are instances where restrictions placed on a diplomate's license do not reflect professionalism concerns or threaten patient safety (e.g., restrictions due to physical limitations or administrative rule violations). Some restrictions are self-imposed while some relate to administrative infractions that, while serious, may not be viewed as a breach of professional norms. Member boards are not investigatory bodies, but they are expected to weigh available evidence and render an informed judgment with due process. Member boards should consider permitting a diplomate to retain a certificate when the diplomate has been successfully participating in physician health programs or other treatment programs recognized by the state medical board. Finally, when a member board takes action on the certification status of a diplomate who

		holds certificates from multiple member boards, the member board must work with ABMS to notify other member boards of the action taken.
	Lifelong Learning	
12	**Program Content and Relevance:** Member boards' continuing certification programs must balance core content in the specialty with practice-specific content relevant to diplomates.	A continuing certification program should reflect the general scope of practice encompassed by a certificate as defined in collaboration with specialty societies, as well as the specific scope of diplomate's practice. To a reasonable degree, customization of required content should occur to enhance clinical relevance of certification.
13	**Assessments of Knowledge, Judgment, and Skills:** Member boards must assess whether diplomates have the knowledge, clinical judgment, and skills to practice safely and effectively in the specialty. Member boards must offer assessment options that have a formative emphasis and that assist diplomates in learning key clinical advances in the specialty.	Assessments should integrate learning opportunities and provide feedback that enhances learning. Member boards may choose to offer point-in-time, secure assessments for diplomates who prefer this approach, provided that the member board can give useful feedback to guide diplomate learning.
14	**Use of Assessment Results in Certification Decisions:** Member boards' continuing certification assessments must meet psychometric and security standards to support making consequential, summative decisions regarding certification status.	Performance on continuing certification assessments should contribute to making certification decisions when assessment is a component of the decision matrix. Continuing certification programs must provide sufficient information upon which to base a decision about a diplomate's certification status. Member boards should ensure that subject matter experts engaging in assessment development are clinically active. In order for users to have confidence in the value of the certificate, sufficient psychometric standards must be met for reliable, fair, and valid assessments to make a consequential (summative) decision. Security methods must be used to determine the identity of the certificate holder while preserving assessment material without creating unnecessary burden for participating diplomates.
15	**Diplomate Feedback from Assessments:** Member board assessments must provide personalized feedback that enhances learning for diplomates.	A member board should provide specific, instructive feedback to each diplomate that identifies their knowledge gaps on assessments. Feedback should also inform any risk to loss of certification. Member boards should work with specialty societies and other stakeholders to identify

		educational resources that address knowledge and skills gaps and to inform diplomates about these. Member boards should also work with specialty societies to allow diplomates to share member board assessment data to support personalized learning plans implemented by specialty societies.
16	**Sharing Aggregated Data to Address Specialty-based Gaps:** Member boards must analyze performance data from their continuing certification program to identify any specialty-based gaps. Aggregated identified gaps should be shared with essential stakeholders, including diplomates, for the development of learning opportunities.	An analysis of performance data allows identification of specialty-specific knowledge gaps. By sharing these data, educational organizations can create targeted learning resources for the benefit of the specialty. Summary data should only be shared with essential stakeholders, such as specialty societies, that require the information for nonprofit service to the profession. Member boards should collaborate with specialty societies in a continual and timely manner to address major public health needs and frequently occurring deficits, engaging specialty societies in the bidirectional communication necessary for further identification and prioritization of gaps.
17	**Lifelong Professional Development:** Member boards' continuing certification programs must reflect principles of Continuing Professional Development (CPD) with an emphasis on clinically oriented, highly relevant content.	Continuing certification should increase a diplomates' knowledge, skills, and abilities that result in the provision of safe, high-quality care to patients. CPD activities must be of high quality and free of commercial bias. Member boards should work with stakeholders to help diplomates identify relevant, high-quality activities and report completion with minimal administrative burden.
	Improving Health and Health Care	
18	**Quality Agenda:** In collaboration with stakeholder organizations, member boards must facilitate the process for developing an agenda for improving the quality of care in their specialties. One area of emphasis must involve eliminating health care inequities.	Member boards are expected to support a quality agenda in alignment with their specialty-at-large. Member boards must collaborate with key organizations, including specialty societies and other quality organizations, to identify areas in which patient care can be improved, review the areas, and define strategies to improve care. To support a quality agenda, member boards should use the common framework developed by the Institute of Medicine for safe, timely, effective, efficient, equitable, and patient-centered care.

19	**Engagement in Improving Health and Health Care:** Member board continuing certification programs must commit to helping the medical profession improve health and health care by: a. Setting goals and meeting progressive participation metrics that demonstrate an ever-increasing commitment toward having all diplomates engaged in activities that improve care; b. Recognizing the quality improvement expertise of partner organizations and seeking collaborative opportunities for diplomate engagement with efforts to improve care through a variety of existing efforts; c. Working with partner organizations, including medical specialty societies, to create systems (e.g., data transfer process), for diplomates engaged in the organizations' quality improvement activities to seamlessly receive credit from the member boards; and d. Modeling continuous quality improvement by evaluating methods and sharing best practices for program implementation and diplomate engagement.	Wherever possible, member boards should align their expectations to existing performance measurement, quality reporting, and quality improvement efforts. Member boards should work with specialty societies and other stakeholders to ensure that opportunities exist for diplomates in all practice settings and in non-clinical roles (e.g., educator, researcher, executive, or advocate). Progressive participation goals may be appropriate for those member boards that are developing new programs or revising current programs.

In May 2021, the ABMS hosted a webinar on the Draft Standards for AMA leadership, including those representing AMA sections and councils. The Council responded to the Call for Comments to the Draft Standards to guide and inform the ABMS board of directors in the development of the final Standards.

CONTINUING BOARD CERTIFICATION: AN UPDATE

The Council and the HOD have carried out extensive and sustained work in developing policy on CBC. This includes working with the ABMS and the American Osteopathic Association (AOA) to provide physician feedback to improve CBC processes, informing our members about progress on CBC through annual reports to the HOD, and developing strategies to address concerns about the CBC processes raised by physicians. The Council has prepared reports covering CBC (formerly titled "Update on Maintenance of Certification and Osteopathic Continuous Certification") for the past 12 years.[1-12] Council members, AMA trustees, and AMA staff have participated in the following meetings with the ABMS and its member boards:

- ABMS Committee on Continuing Certification
- ABMS Stakeholder Council
- ABMS Accountability and Resolution Committee
- ABMS 2020 Annual Conference
- AMA Council on Medical Education 2020-2021 meetings

ABMS Committee on Continuing Certification

The ABMS Committee on Continuing Certification (known as "3C") is charged with overseeing the review process to CBC programs of the 24 member boards as well as the policies and procedures followed by the boards. Through 3C activities, the member boards share best practices in designing, implementing, and promoting continuing certification as individual member boards continue to receive input from subject matter experts researching physician competence, performance standards, continuing professional development, security considerations, and psychometric characteristics of longitudinal assessment programs.

During 2020 and 2021, the 3C continued to approve substantive program changes implemented among the ABMS member boards and announced additional pilot programs intended to enhance relevance to practice and improve diplomate satisfaction, while maintaining the rigor of assessment, education, and improvement components. This committee sought to improve the level of detail and analysis regarding the approval processes for assessment of new pilots and for adoption of substantive changes by aligning these review processes. This includes utilization of a third reviewer as a technical expert for assessment of new pilots. This third reviewer is designated as a member board staff volunteer (psychometrician or other staff with expertise in assessment design or administration) who provides additional technical expertise in the realm of assessment in recommended areas of analysis.

The 3C also participated in the review of the Draft Standards for Continuing Certification during the Call for Comments period. The committee continues to include AMA representation for monitoring issues of importance to multiple certificate holders, holders of cosponsored certificates, and physicians trained through non-Accreditation Council for Graduate Medical Education-approved pathways.

ABMS Stakeholder Council

Formed in 2018, the Stakeholder Council is an advisory body representing the interests of active diplomate physicians, patients, and the public. It was established to ensure that the decisions of the ABMS Board of Directors are grounded in an understanding of the perspectives, concerns, and interests of the multiple constituents impacted by the ABMS' work. The Stakeholder Council also provides guidance to the Vision Commission and its implementation plan.

During 2020-21 meetings, the Stakeholder Council reviewed and provided feedback to the ABMS regarding the Draft Standards for Continuing Certification, the ABMS Certification Matters display research project and its goals, and this Council's workgroup product regarding diversity and equity. Ongoing work within the Stakeholder Council discusses how the ABMS and its member boards can effectively communicate the evolving process of continuing certification that better balances the value of learning and assessment for physicians, while meeting the needs of the public for a meaningful credential. Issues identified as an important part of this Council's charge include sharing research, promoting best practices for new/emerging technologies, developing novel assessment techniques, aligning continuing certification activities with national reporting and licensure requirements, strengthening relationships between boards and specialty societies, and engaging in patient advocacy.

ABMS Accountability and Resolution Committee

The ABMS Accountability and Resolution Committee (ARC) is continuing its review of how the ABMS member boards engage with ABMS' eight organizational standards. These standards, which

address issues related to member board governance, financial and organizational management, and stakeholder engagement, among others, are being reviewed with the intent of identifying best practices among the member boards that can be shared and scaled.

ABMS 2020-2021 Annual Conferences

Amidst the rapidly changing COVID-19 environment, the ABMS and its member boards continue to focus on delivering the value of board certification by convening virtually during the pandemic. For example, during the 2020 Annual Conference, held September 23-24, 2020, educational tracks featured current priorities and enduring principles related to the value of board certification, innovative assessments, and professionalism. This meeting also explored the impact of COVID-19 as well as topics on diversity, equity, and inclusion. AMA's past president, Patrice A. Harris, MD, MA, was featured in a plenary panel session entitled "Improving Public Health Through Diversity, Equity, and Inclusion."

The 2021 Annual Conference, "Transforming Certification for Better Care," was held virtually September 28-29, 2021. AMA staff leadership played key roles in the presenting of information. Jodi Abbott, MD, MSc, MHCM, Medical Director of Curriculum and Outreach for the AMA Ed Hub™, led a panel discussion on the elements and perspectives required in the design, development, editing, and publishing of foundational health equity education. This session illuminated how COVID-19, and other determinants of health, uniquely impact historically marginalized and minoritized communities. Also, AMA leaders Marie T. Brown, MD, MACP, Director of Practice Redesign, and Christine Sinsky, MD, MACP, Vice President, Professional Satisfaction, spoke in the plenary sessions "Addressing Health Care Disparities and the Role of the ABMS Community" and "Addressing Physician Well-being and Burnout: The Present and Future Role of Continuing Certification," respectively.

AMA Council on Medical Education 2020-2021 meetings

At the August 2020 as well as the March and November 2021 meetings of the Council, Richard Hawkins, MD, CEO of the ABMS, presented updates to the Council related to the Vision Commission and Standards. These meetings provided the Council with opportunities to ask questions and give real-time feedback.

ABMS Continuing Certification Directory

The ABMS Continuing Certification Directory provides ABMS board-certified physicians access to an online repository of practice-relevant, competency-based, accredited continuing medical education (CME) activities for continuing certification by participating member boards. During the past year, the Directory has increased its inventory and now indexes more than 4,000 open-access CME activities from more than 65 accredited CME providers. The inventory includes Opioid Prescriber Education Programs and other national health and quality priorities to help diplomates address national health priorities through continuing certification requirements for Lifelong Learning and Self-Assessment (Part II). Working in collaboration with the JAMA Network, the Continuing Certification Directory currently indexes individual journal-based and enduring CME activities across the JAMA Network. This collaboration has improved access to practice-relevant education opportunities as well as the representation of these learning formats across the CME enterprise.

With the Directory, diplomates can strategically align CME with member boards' Continuing Certification Programs. The competency-based activities are routinely added following the review

and approval by one or more of the ABMS member boards. All activities are accredited for CME by the Accreditation Council for Continuing Medical Education (ACCME).

In addition, the ABMS offers a Continuing Certification Reference Center, a searchable resource on its website that highlights literature relevant to member board certification and continuing certification. This reference center, provided by the Research and Education Foundation, is a dynamic database which grows as new studies, reviews, and commentaries are published.

ACCME updates and resources

The ACCME continues to support the continuing certification of physicians. CME Finder is a free search tool that helps physicians find accredited CME activities that meet their needs. In the last year, the ACCME has added more activities and enhancements to this tool to reduce burdens on learners and better serve accredited CME providers as well as to meet the needs of credentialing, certifying, and licensing authorities. These enhancements include the following:

- Ability to display any current or future activities that the accredited CME provider chooses to include as activities that are registered for Improvement in Medical Practice (IMP/Part IV) as well as Merit-Based Incentive Payment System (MIPS) or Risk Evaluation and Mitigation Strategies (REMS);
- Enabling physicians to create a personalized account to view their reported CME and IMP credits and generate transcripts for their state medical board, certifying board, employer, or other regulatory authority; and
- Searchability by activity format, date, types of credit offered, topic, location, keyword, specialty, and other filters.

In late summer 2021, the ACCME launched a new and improved Program and Activity Reporting System (PARS), the system used by accredited CME providers to report their activities and participate in the reaccreditation progress. The new PARS gives accredited CME providers the option to enter, track, and manage physician-learner data for all accredited activities, including activities for IMP. These enhancements support the value of accredited CME and lifelong learning.

The ACCME released its 2020-2021 Highlights Report, "Learning to Thrive Together," which outlines the key initiatives aimed to respond to the CME community's recommendations, fulfill strategic goals, and support a shared mission to improve care for patients and communities. Key takeaways are that the ACCME in 2020-2021:

- Continued to offer new accommodations and resources to help the accredited education community adapt to new circumstances.
- Provided an expedited pathway for planning activities related to COVID-19, a searchable database for vaccine-related education, and guidance for transitioning to virtual learning formats.
- Released the Standards for Integrity and Independence in Accredited Continuing Education, delivering on a promise to health care professionals that they can trust accredited continuing education to provide accurate, balanced, evidence-based information that supports high-quality patient care.
- Launched CME Passport, a free, all-in-one web application that enables physicians to find, track, and manage their CME.
- Expanded collaborations with colleague regulatory bodies, with the goal of reducing CME-reporting burdens for physicians, giving them more time to focus on their education and patient care, rather than on compliance.

- Convened a special task force of the ACCME Board of Directors to explore the fostering of learning environments that promote diversity, health equity, and inclusiveness, as well as the facilitation of meaningful change in accredited education.

Update on Alternatives to the Secure, High-Stakes Examination/ Part III

All 24 ABMS member boards have moved away from the secure, high-stakes exam, to offer assessment options that combine adult learning principles with state-of-the-art technology, enabling delivery of assessments that promote ongoing learning and are less stressful. Fourteen member boards have implemented and/or are piloting a longitudinal assessment approach, which involves repeatedly administering shorter assessments of specific content, such as medical knowledge, over a period of time. Seven of these boards are using CertLink®, a technology platform developed by the ABMS to support the boards in delivering more frequent, practice-relevant, and user-friendly competence assessments to physicians. Sixteen member boards have retained the traditional secure exam option for reentry purposes and for diplomates who prefer this exam method.

Several boards leveraged their longitudinal assessment platforms to create and distribute up-to-date assessment items on COVID-19. The disruptions of COVID-19 prompted some member boards to make temporary changes to requirements for certification; according to the ABMS, per information obtained from 23 of the member boards regarding these changes, eight offered certificate extensions (three automatically; five by request). In addition, several boards offered extensions (six automatically; five by request) or modifications (three automatically; one by request) to Part III. Given the fluidity of the pandemic, other adjustments may have been or are being made that are not fully reflected in this report.

In April 2021, the American Board of Surgery (ABS) announced that it launched a pilot program in video-based assessment (VBA), taking place from June to December 2021, to help the ABS investigate the use of VBA as a component of its Continuous Certification Program and assess the feasibility of full implementation in the future. In this pilot, surgeons will upload videos of their operations from a predefined list of procedures and will be asked to review videos of their peers. They will provide feedback on their experience with the platform and overall experience with VBA. Videos will be de-identified for surgeon and patient anonymity. Pilot participants will receive quantitative and qualitative feedback on their technique. The ABS will have access to identified information only with respect to who completed uploads and reviews and to de-identified information on ratings, engagement, performance data, and other key performance indicators as defined prior to the pilot.

Progress with Refining IMP/ Part IV

The ABMS member boards continue to expand the range of acceptable activities that meet the IMP requirements, including those offered at the physician's institution and/or individual practices, to address physician concerns about the relevance, cost, and burden associated with fulfilling those requirements (Appendix A). In addition to improving alignment between national value-based reporting requirements and continuing certification programs, the boards are implementing several activities related to registries, practice audits, and systems-based practice.

As described in the previous report,[1] several ABMS member boards have continued to innovate in the CBC space by developing online practice assessment protocols and tools that allow physicians to assess patient care using evidence-based quality indicators. Boards are also partnering with specialty societies to design population-based activities, integrating patient experience and peer review into IMP requirements, including simulation options, and allowing for personalized

activities using data from a physician's own practice. The American Board of Family Medicine (ABFM) worked with four institutions to successfully create registries of measures that matter, despite the challenges of bringing consistency to the measures across the different institutions.

Amidst the challenges of COVID-19, the ABMS member boards continued to align CBC activities with other organizations' quality improvement (QI) efforts to reduce redundancy and physician burden while promoting meaningful participation. Many of the boards encouraged participation in organizational QI initiatives through the ABMS Multi-Specialty Portfolio Program™. According to the ABMS, per information obtained from 23 of the member boards regarding temporary changes to continuing certification due to COVID-19, several boards offered extensions (four automatically; five by request) or modifications (two automatically) to IMP/Part IV. Given the fluidity of the pandemic, other adjustments may have been or are being made that are not fully reflected in this report. Appendix B offers detailed information per board as to the temporary changes offered for continuing as well as initial certification.

ABMS Multi-Specialty Portfolio Program

The ABMS Portfolio Program (Portfolio Program™) supports health care organizations' quality and safety goals, encourages physician and physician assistant involvement in QI activities, and offers continuing certification credit for the improvement work being done in practice. Through the Portfolio Program™ community, individuals and organizations share resources and camaraderie, make strategic connections, and provide advice and feedback to other sponsor organizations. The Portfolio Program™ community includes hospitals, academic medical centers, integrated delivery systems, interstate collaboratives, specialty societies, state medical societies, and other types of organizations in the physician QI/education space. More than 4,500 QI projects have been approved by the Portfolio Program in which 18 ABMS member boards participate, focusing on such areas as COVID-19, health care inequities, advanced care planning, cancer screening, cardiovascular disease prevention, depression screening and treatment, provision of immunizations, obesity counseling, patient-physician communication, transitions of care, and patient-safety-related topics including sepsis and central line infection reduction. Many of these projects have had a positive impact on patient care and outcomes. To date, there have been nearly 47,000 instances of physicians receiving continuing certification credit through participation in the Portfolio Program™.

Specific to COVID-19, nearly 700 individual activities have been submitted by sponsor organizations participating in the Portfolio Program. These projects were related to or included the implementation of telehealth, process redesign, medication, intubation, contact tracing, vaccinations, and more. Through these activities, roughly 3,000 physicians and physician assistants have received credit.

Recent additions among the nearly 100 current Portfolio Program sponsors include the Perelman School of Medicine at the University of Pennsylvania, the Professional Renewal Center, and Rainbow Babies & Children's Hospital at Case Western University. The full list of sponsors is available on the ABMS Portfolio Program website.

The AMA is also a sponsor in the Portfolio Program, having published several Performance Improvement CME activities which also offered IMP credit. Two activities launched in May 2021, "Screening for Abnormal Blood Glucose" and "Intervention for Abnormal Blood Glucose in Prediabetes Range," provide a streamlined learner experience. In October 2021, two additional activities were launched, "Retesting of Abnormal Blood Glucose in Patients with Prediabetes" and "Improving BMI Documentation and Follow-Ups." These activities support the AMA's ongoing

efforts to improve health outcomes, particularly the prevention of diabetes; they can be found on the AMA's Ed Hub™.

Update on the Emerging Data and Literature Regarding the Value of CBC

The Council has continued to review published literature and emerging data as part of its ongoing efforts to critically review CBC. The annotated bibliography in Appendix C provides a list of recent studies, editorials, and announcements. Such information addresses ABMS member board history, initiatives, and advancements as well as concerns, challenges, and considerations for the future. The appendix also provides information on CBC in Canada and Europe.

OSTEOPATHIC CONTINUOUS CERTIFICATION: AN UPDATE

The American Osteopathic Association (AOA) offers board certification in 27 primary specialties and 48 subspecialties (including certifications of added qualifications). Nine of the 48 subspecialties are conjoint certifications managed by multiple AOA specialty boards. As of December 31, 2021, a total of 38,355 physicians held 45,128 active certifications issued by the AOA's specialty certifying boards.

The AOA Certifying Board Services Department works in collaboration with the 16 osteopathic medical specialty certifying boards on the development and implementation of certification programs and assessments. Under the guidance of the AOA Bureau of Osteopathic Specialists, specialty certifying boards commit to enhancing board certification services that better serve candidates and diplomates pursuing and maintaining AOA board certification.

AOA specialty certifying boards provide a modernized, expedited approach to the delivery of relevant and meaningful competency assessment for board certified diplomates. Through innovation and leveraging technology opportunities, all AOA specialty boards have developed longitudinal assessment programs that replaced the high stakes recertification exams previously required. Several AOA specialty certifying boards, including Anesthesiology, Emergency Medicine, Family Medicine, General Surgery, Internal Medicine, Neurology & Psychiatry, Obstetrics & Gynecology, and Radiology have successfully launched their longitudinal assessment programs. The remaining primary specialty certifying boards remain on schedule to launch longitudinal assessment programs by the end of 2022.

To provide added convenience for AOA diplomates and in service of a long-range goal to improve user experience, every AOA specialty certifying board now offers its candidates and diplomates online remote proctored delivery of its certification and Osteopathic Continuous Certification (OCC) exams. Operational improvements were made within the department, which has resulted in reduced processing time for exam score reporting and enhanced psychometric exam validation.

CURRENT AMA POLICIES RELATED TO CBC

The AMA maintains robust policy related to CBC and lifelong learning, which can be accessed in the AMA PolicyFinder database. Specifically, Policies H-275.924 and D-275.954, both entitled "Continuing Board Certification," and H-275.926, "Medical Specialty Board Certification Standards," can be found in Appendix D.

DISCUSSION

The Council is actively engaged in the implementation of the Vision for the Future Commission's recommendations and standards to improve the process for the more than 640,000 diplomates participating in continuing certification (unpublished data, ABMS Diplomate Database, accessed July 1, 2021, with permission from ABMS). This report highlights the progress the ABMS and ABMS member boards have continued to make to ease burdens and improve the CBC process for physicians.

Council on Medical Education Report (CME 1-N-20), "An Update on Continuing Board Certification," considered at the Special November 2020 Meeting, recommended that our AMA, "through its Council on Medical Education, continue to work with the ABMS and its member boards to implement key recommendations outlined by the Vision Commission's final report, including the development of new, integrated standards for continuing certification programs by 2020 that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency." The recommendation was appended to AMA Policy D-275.954 as the 38th clause. However, the impact of COVID-19 led to the delay in the release of the new Draft Standards until 2021. The ABMS Board of Directors considered the feedback on the Draft Standards at their October 2021 meeting, and the final Standards were released shortly thereafter. Therefore, this report proposes to amend the policy to strike "2020" as well as to include language supporting the new Standards. Upon further review of this policy, another inaccuracy was noted. The 22nd clause of this policy refers to the AMA's continued participation in the National Alliance for Physician Competence; this Alliance was renamed the Coalition for Physician Accountability, and policy should reflect the current name.

Policy adopted at the June 2021 Special Meeting, now appended to AMA Policy D-275.954, "Continuing Board Certification," asks that our AMA "work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures." The impetus for this policy is that many physicians are certified by more than one ABMS Board but may participate in CBC with only one of those boards. As one example, the American Board of Internal Medicine (ABIM) charges such physicians a fee and does not accurately reflect such physicians' status as participating in CBC in the ABIM Directory unless they pay that fee. The Council is in regular communication with the ABMS regarding these concerns raised.

Existing AMA policy is supportive of cost transparency as well as reduced financial burdens on physicians in their achievement of continuing certification. Policy H-275.924(19) states that "the CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care." Also, Policy D-275.954 states that our AMA will "encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring, and reporting CBC and certifying examinations" and "encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle."

Since 2007, the Council has provided an annual report on CBC per AMA Policy D-275.954. Given advancements and improvements made in the field of CBC, the Council believes it is no longer

imperative to provide a report every year. The Council continues to monitor the CBC process and will submit a report to the HOD when deemed necessary.

SUMMARY AND RECOMMENDATIONS

The AMA has been actively engaged in the implementation of the Continuing Board Certification: Vision for the Future Commission's recommendations as well as the development of the Draft Standards to contribute to the improvement of the continuing board certification process. The Council continues to monitor the development of continuing board certification programs and to work with the ABMS, ABMS member boards, AOA, and state and specialty medical societies to identify and suggest improvements to these programs.

The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of the report be filed.

That our American Medical Association (AMA) amend Policy D-275.954 clauses 1, 22, and 38 by addition and deletion to read as follows:

1. (1), "Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a ~~yearly~~ report to the House of Delegates regarding the CBC process when necessary <u>as determined by the Council on Medical Education</u>."

2. (22), "Continue to participate in the <u>Coalition for Physician Accountability, formerly known as the</u> National Alliance for Physician Competence forums."

3. (38), "Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development and release of new, integrated standards for continuing certification programs ~~by 2020~~ that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency." (Modify Current HOD Policy)

Fiscal Note: $3,000

APPENDIX A:
IMPROVEMENTS TO ASSESSMENT OF KNOWLEDGE, JUDGMENT, AND SKILLS (PART III) AND IMPROVEMENT IN MEDICAL PRACTICE (PART IV)*

American Board of:	Original Format	New Models/Innovations
Allergy and Immunology (ABAI) abai.org	**Part III:** Computer-based, secure exam was administered at a proctored test center once a year. Diplomates were required to pass the exam once every 10 years. *Traditional secure exam only offered for re-entry.*	**Part III:** In 2018, ABAI-Continuous Assessment Program was implemented in place of 10-year secure exam: • A 10-year program with two 5-year cycles; • Open-book with approximately 80 questions annually; • Customized to practice; • Diplomates must answer three questions for each of 10 journal articles in each cycle posted in February and August; • 10 core questions during each 6-month cycle; • Questions can be answered independently for each article; • Diplomate feedback required on each question; • Opportunity to drop the two lowest 6-month cycle scores during each 5-year period to allow for unexpected life events; and • Diplomates can take exam where and when it is convenient and have the ability to complete questions on PCs, laptops, MACs, tablets, and smart phones by using the new diplomate dashboard accessed via the existing ABAI Web Portal page.
	Part IV: ABAI diplomates receive credit for participation in registries.	**Part IV:** In 2018, new Part IV qualifying activities provided credit for a greater range of Improvement in Medical Practice (IMP) activities that physicians complete at their institutions and/or individual practices. A practice assessment/quality improvement (QI) module must be completed once every 5 years.

Anesthesiology (ABA) theaba.org	**Part III:** MOCA 2.0 introduced in 2014 to provide a tool for ongoing low-stakes assessment with more extensive, question-specific feedback. Also provides focused content that could be reviewed periodically to refresh knowledge and document cognitive expertise.	**Part III:** MOCA Minute® replaced the MOCA exam: • Customized to practice; • Diplomates must answer 30 questions per calendar quarter (120 per year), no matter how many certifications they are maintaining; and • Knowledge Assessment Report shows details on the MOCA Minute questions answered incorrectly, peer performance, and links to related CME.
	Part IV[2]: Traditional MOCA requirements include completion of case evaluation and simulation course during the 10-year MOCA cycle. One activity must be completed between Years 1 to 5 and the second between Years 6 to 10. An attestation is due in Year 9.	**Part IV[2]:** ABA added and expanded multiple activities for diplomates to demonstrate that they are participating in evaluations of their clinical practice and are engaging in practice improvement. Diplomates may choose activities that are most relevant to their practice; reporting templates no longer required for self-report activities; and simulation activity not required. An attestation is due in Year 9.
Colon and Rectal Surgery (ABCRS) abcrs.org	**Part III:** Computer-based secure exam administered at a proctored test center once a year (in May). Diplomates must pass the exam once every 10 years. *The secure exam is no longer offered.*	**Part III[1]:** New Continuous Certification Longitudinal Assessment Program (CertLink®) replaced the high-stakes Part III Cognitive Written Exam which was required every 10 years: • Diplomates must complete 12 to 15 questions per quarter through the CertLink® platform. • The fifth year of the cycle can be a year free of questions or used to extend the cycle if life events intervene.
	Part IV: Requires ongoing participation in a local, regional, or national outcomes registry or quality assessment program.	**Part IV:** If there are no hospital-based or other programs available, diplomates can maintain a log of their own cases and morbidity outcomes utilizing the ACS Surgeon Specific Case Log System (with tracking of 30-day complications). Resources are provided to enable completion of QI activities based on the results.

Dermatology (ABD) abderm.org	**Part III:** Computer-based secure modular exam still administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years. Test preparation material available 6 months before the exam at no cost. The material includes diagnoses from which the general dermatology clinical images will be drawn and questions that will be used to generate the subspecialty modular exams. Examinees are required to take the general dermatology module, consisting of 100 clinical images to assess diagnostic skills, and can then choose among 50-item subspecialty modules.	**Part III[1]:** ABD completed trials employing remote proctoring technology to monitor exam administration in the diplomates' homes or offices. On January 6, 2020, diplomates can participate in CertLink®: • Diplomates must complete 13 questions per quarter for a total of 52 questions; • Diplomates will receive a mix of visual recognition questions, specialty area questions, and article-based questions; • Written references and online resources are allowed while answering questions; and • Diplomates are permitted to take one quarter off per year without advanced permission or penalty, using the "Time Off" feature (if diplomate opts not to take a quarter off, their lowest scoring quarter during that year will be eliminated from scoring).
	Part IV[2]: Tools diplomates can use for Part IV include: • Focused practice improvement modules. • ABD's basal cell carcinoma registry tool. Partnering with specialty society to transfer any MOC-related credit directly to Board.	**Part IV[2]:** ABD developed more than 40 focused practice improvement modules that are simpler to complete and cover a wide range of topics to accommodate different practice types. Peer and patient communication surveys are now optional.
Emergency Medicine (ABEM) abem.org	**Part III:** ABEM's ConCert™, computer-based, secure exam administered at a proctored test center twice a year. Diplomates must pass the exam once every 10 years. *ConCert will be phased out after 2022*	**Part III:** ABEM launched an alternative assessment, MyEMCert, that consists of: • Short assessment modules, consisting of up to 50 questions each; • Each module addresses a category of common patient presentations in the emergency department; • Eight modules are required in each 10-year certification. (ABEM-diplomates who have less than 10 years remaining on their current certification and who choose to participate in MyEMCert will have less time to complete eight modules before their certification expires); • Each module includes recent advances in emergency medicine

		(that may or may not be related to the category of patient presentation). Participants in MyEMCert do not also have to take LLSAs; • Three attempts are available for each registration; • MyEMCert modules will be available 24/7/365; and • Diplomates can look up information—for example, textbooks or online resources to which they subscribe—while completing a module.
	Part IV[2]: Physicians may complete practice improvement efforts related to any of the measures or activities listed on the ABEM website. Others that are not listed, may be acceptable if they follow the four steps ABEM requirements.	**Part IV[2]:** ABEM is developing a pilot program to grant credit for participation in a clinical data registry. ABEM diplomates receive credit for improvements they are making in their practice setting. Must complete and attest to two performance improvement activities, one in years one through five of certification and one in years six through ten.
Family Medicine (ABFM) theabfm.org	**Part III:** One-day Family Medicine Certification Exam. Traditional computer-based secure exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years. The exam day schedule consists of four 95-minute sections (75 questions each) and 100 minutes of pooled break time available between sections.	**Part III:** In 2018, ABFM launched Family Medicine Certification Longitudinal Assessment (FMCLA), • Diplomates must complete 25 questions per quarter; 300 questions over a 4-year time period; • Diplomates receive immediate feedback after each response; • Clinical references similar to those used in practice allowed during the assessment; and • Questions can be completed at the place and time of the diplomate's choice.
	Part IV[2]: IMP Projects include: • Collaborative Projects: Structured projects that involve physician teams collaborating across practice sites and/or institutions to implement strategies designed to improve care. • Projects Initiated in the Workplace: These projects are based on identified gaps in quality in a local or small group setting.	**Part IV[2]:** ABFM developed and launched the national primary care registry (PRIME) to reduce time and reporting requirements.

	• Web-based Activities: Self-paced activities that physicians complete within their practice setting (these activities are for physicians, who do not have access to other practice improvement initiatives).	
Internal Medicine (ABIM) abim.org	**Part III:** Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. This option includes open-book access (to UpToDate®) that physicians requested. *ABIM introduced grace period for physicians to retry assessments for additional study and preparation if initially unsuccessful.*	**Part III:** ABIM will be piloting a longitudinal assessment option in 2022. *ABIM has developed collaborative pathways with the American College of Cardiology and American Society of Clinical Oncology for physicians to maintain board certification in several subspecialties. ABIM is working with other specialty societies to explore the development of pathways.*
	Part IV[2]: Practice assessment/QI activities include identifying an improvement opportunity in practice, implementing a change to address that opportunity, and measuring the impact of the change. Diplomates can earn MOC points for many practice assessment/QI projects through their medical specialty societies, hospitals, medical groups, clinics, or other health-related organizations.	**Part IV[2]:** Optional; incentive for participation in approved activities. Increasing number of specialty-specific IMP activities recognized for credit (activities that physicians are participating in within local practice and institutions).

Medical Genetics and Genomics (ABMGG) abmgg.org	**Part III:** Computer-based secure exam administered at a proctored test center once a year (August). Diplomates must pass the exam once every 10 years. *The secure exam is no longer offered.*	**Part III[1]:** ABMGG offers a longitudinal assessment program (CertLink®) • Diplomates receive 24 questions every 6 months, regardless of number of specialties in which a diplomate is certified; • Diplomates must answer all questions by the end of each 6-month timeframe (5 minutes allotted per question); • Resources allowed, collaboration with colleagues not allowed; • Realtime feedback and performance provided for each question; and • "Clones" of missed questions will appear in later timeframes to help reinforce learning.
	Part IV[2]: Diplomates can choose from the list of options to complete practice improvement modules in areas consistent with the scope of their practice.	**Part IV[2]:** ABMGG is developing opportunities to allow diplomates to use activities already completed at their workplace to fulfill certain requirements. *Expanding accepted practice improvement activities for laboratorians.*
Neurological Surgery (ABNS) abns.org	**Part III:** The 10-year secure exam can be taken from any computer, e.g., in the diplomate's office or home. Access to reference materials is not restricted; it is an open book exam. On applying to take the exam, a diplomate must assign a person to be their proctor. Prior to the exam, that individual will participate in an on-line training session and "certify" the exam computers. *The secure exam is no longer offered.*	**Part III:** In 2018, Core Neurosurgical Knowledge, an annual adaptive cognitive learning tool and modules, replaced the 10-year secure exam: • Open book exam focusing on 30 or so evidence-based practice principles critical to emergency, urgent, or critical care; • Shorter, relevant, and more focused questions than the prior exam; • Diplomates receive immediate feedback for each question and references with links and/or articles are provided; and • Web-based format with 24/7 access from the diplomate's home or office.

	Part IV: Diplomates receive credit for documented participation in an institutional QI project.	**Part IV:** Diplomates are required to participate in a meaningful way in morbidity and mortality conferences (local, regional, and/or national). For those diplomates participating in the Pediatric Neurosurgery, CNS-ES, NeuCC focused practice programs, a streamlined case log is required to confirm that their practice continues to be focused and the diplomate is required to complete a learning tool that includes core neurosurgery topics and an additional eight evidence-based concepts critical to providing emergency, urgent, or critical care in their area of focus.
Nuclear Medicine (ABNM) abnm.org	**Part III:** Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.	**Part III[1]:** Diplomates can choose between the 10-year exam or a longitudinal assessment program (CertLink®). • Diplomates receive nine questions per quarter and up to four additional questions that are identical or very similar to questions previously answered (called "clones") and many will have images; • Educational resources can be used; • Diplomates receive immediate feedback with critiques and references; and • Allows for emergencies and qualifying life events.
	Part IV: Diplomates must complete one of the three following requirements each year. 1. Attestation that the diplomate has participated in QI activities as part of routine clinical practice, such as participation in a peer review process, attendance at tumor boards, or membership on a radiation safety committee. 2. Participation in an annual practice survey related to approved clinical guidelines released by the ABNM. The survey has several questions based on review of actual cases. Diplomates receive a summary of the answers provided by other physicians that allows them to compare their practice to peers. 3. Improvement in Medical Practice projects designed by diplomates or	**Part IV:** ABNM recognizes QI activities in which physicians participate in their clinical practice.

	provided by professional groups such as the SNMMI. Project areas may include medical care provided for common/major health conditions; physician behaviors, such as communication and professionalism, as they relate to patient care; and many others. The projects typically follow the model of Plan, Do, Study, Act. The ABNM has developed a few IMP modules for the SNMMI, Alternatively, diplomates may design their own project.	
Obstetrics and Gynecology (ABOG) abog.org	**Part III:** The secure, external assessment is offered in the last year of each ABOG diplomate's 6-year cycle in a modular test format; diplomates can choose two selections that are the most relevant to their current practice. The exam administered at a proctored test center.	**Part III:** ABOG integrated the article-based self-assessment (Part II) and external assessment (Part III) requirements, allowing diplomates to continuously demonstrate their knowledge of the specialty. Diplomates can earn an exemption from the current computer-based exam in the sixth year of the program if they reach a threshold of performance during the first 5 years of the self-assessment program. Since 2019, diplomates can choose to take the 6-year exam or participate in Performance Pathway, an article-based self-assessment (with corresponding questions) which showcases new research studies, practice guidelines, recommendations, and up-to-date reviews. Diplomates who participate in Performance Pathway are required to read a total of 180 selected articles and answer 720 questions about the articles over the 6-year MOC cycle.
	Part IV[2]: Diplomates required to participate in one of the available IMP activities yearly in MOC Years 1-5. ABOG will consider structured QI projects (IMP modules, QI efforts, simulation courses) in obstetrics and gynecology for Part IV credit. These projects must demonstrate improvement in care and be based on accepted improvement science and methodology. Newly developed QI projects from organizations with a history of successful QI projects are also eligible for approval.	**Part IV[2]:** ABOG recognizes work with QI registries for credit. ABOG continues to expand the list of approved activities which can be used to complete the Part IV.

Ophthalmology (ABO) abop.org	**Part III:** The Demonstration of Ophthalmic Cognitive Knowledge (DOCK) high-stakes, 10-year exam administered through 2018. *The secure exam is no longer offered.*	**Part III:** In 2019, Quarterly Questions™ replaced the DOCK Examination for all diplomates: • Diplomates receive 50 questions (40 knowledge-based and 10 article-based); • The questions should not require preparation in advance, but a content outline for the questions will be available; • The journal portion will require reading five articles from a list of key ophthalmic journal articles with questions focused on the application of this information to patient care; • Diplomates receive immediate feedback and recommendations for resources related to gaps in knowledge; and • Questions can be completed remotely at home or office through computer, tablet, or mobile apps.
	Part IV[2]: Diplomates whose certificates expire on or before December 31, 2020, must complete one of the following options; all other diplomates complete two activities: • Read QI articles through Quarterly Questions; • Choose a QI CME activity; • Create an individual IMP activity; or • Participate in the ABMS multi-specialty portfolio program pathway.	**Part IV[2]:** Diplomates can choose to: • Select 3 QI journal articles from ABO's reading list and answer two questions about each article (this activity option may be used only once during each 10-year cycle). • Design a registry-based IMP Project using their AAO IRIS® Registry Data; • Create a customized, self-directed IMP activity; or • Participate in the ABMS multi-specialty portfolio program through their institution.
Orthopaedic Surgery (ABOS) abos.org	**Part III:** Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. The optional oral exam is given in Chicago in July. Diplomates without subspecialty certifications can take practice-profiled exams in orthopaedic sports medicine and surgery of the hand.	**Part III:** ABOS offers a longitudinal assessment program (ABOS WLA) the Knowledge Assessment. This pathway may be chosen instead of an ABOS computer-based or oral recertification 10-year exam: • Diplomates must answer 30 questions (from each Knowledge Source chosen by the diplomate); • The assessment is open-book and diplomates can use the Knowledge

	General orthopaedic questions were eliminated from the practice-profiled exams, so diplomates are only tested in areas relevant to their practice. Detailed blueprints are being produced for all exams to provide additional information for candidates to prepare for and complete the exams. Eight different practice-profiled exams offered to allow assessment in the diplomate's practice area.	Sources, if the questions are answered within the 3-minute window and that the answer represents the diplomate's own work; and • Questions can be answered remotely at home or office through computer, tablet, or mobile apps.
	Part IV: Case lists allow diplomates to review their practice including adhering to accepted standards, patient outcomes, and rate and type of complications. Case list collection begins on January 1st of the calendar year that the diplomate plans to submit their recertification application and is due by December 1. The ABOS recommends that this be done in Year 7 of the 10-year MOC Cycle, but it can be done in Year 8 or 9. A minimum of 35 cases is required for the recertification candidate to sit for the recertification exam of their choice. Diplomates receive a feedback report based on their submitted case list.	**Part IV:** ABOS is streamlining the case list entry process to make it easier to enter cases and classify complications.
Otolaryngology – Head and Neck Surgery (ABOHNS) aboto.org	**Part III:** Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	**Part III[1]:** CertLink®-based longitudinal assessment: • Diplomates receive 10 to 15 questions per quarter; • Immediate, personalized feedback provided regarding the percentage of questions answered correctly; • Questions can be answered at a diplomate's convenience so long as all questions are answered by the end of each quarter; and • Remote access via desktop or laptop computer (some items will contain visuals).
	Part IV[2]: The three components of Part IV include: • A patient survey; • A peer survey; and • A registry that will be the basis for QI activities.	**Part IV[2]:** ABOHNS is partnering with the American Academy of Otolaryngology-Head and Neck Surgery in their development of a RegentSM registry. Selected data will be extracted from RegentSM for use in practice improvement modules that diplomates can use to meet IMP requirements. ABOHNS is working to identify and accept improvement

		activities that diplomates engage in as part of their practice. ABOHNS will roll out the last section of MOC, Part IV, which is still under development. Part IV will consist of three components, a patient survey, a professional survey, and a Performance Improvement Module (PIM).
Pathology (ABPath) abpath.org	**Part III:** Computer-based secure modular exam administered at the ABP Exam Center in Tampa, Florida twice a year (March and August). Remote computer exams can be taken anytime 24/7 that the physician chooses during the assigned 2-week period (spring and fall) from their home or office. Physicians can choose from more than 90 modules, covering numerous practice areas for a practice-relevant assessment. Diplomates must pass the exam once every 10 years.	**Part III[1]:** The ABPath CertLink® program is available for all diplomates: • Customization allows diplomates to select questions from practice (content) areas relevant to their practice. • Diplomates can log in anytime to answer 15 to 25 questions per quarter; • Each question must be answered within 5 minutes; • Resources (e.g. internet, textbooks, journals) can be used; and • Diplomates receive immediate feedback on whether each question is answered correctly or incorrectly, with a short narrative about the topic (critique), and references.
	Part IV[2]: Diplomates must participate in at least one inter-laboratory performance improvement and quality assurance program per year appropriate for the spectrum of anatomic and clinical laboratory procedures performed in that laboratory.	**Part IV[2]:** IMP requirements must be reported as part of a reporting period every 2 years via PATHway. There are three aspects to IMP: • Laboratory Accreditation; • Laboratory Performance Improvement and Quality Assurance; and • Individual Performance Improvement and Quality Assurance.
Pediatrics (ABP) abp.org	**Part III:** Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	**Part III:** In 2019, a new testing platform with shorter and more frequent assessments, Maintenance of Certification Assessment for Pediatrics (MOCA-Peds), was implemented: • Allows for questions to be tailored to the pediatrician's practice profile; • A series of questions released through mobile devices or a web browser at regular intervals;

		• Diplomates receive 20 questions per quarter (may be answered at any time during the quarter); • Diplomates receive immediate feedback and references; • Resources (e.g., internet, books) can be used. *Those who wish to continue taking the exam once every 5 years in a secure testing facility will be able to do so.*
	Part IV[2]: Diplomates must earn at least 40 points every 5 years in one of the following activities: • Local or national QI projects • Diplomates' own project • National Committee for Quality Assurance Patient-Centered Medical Home or Specialty Practice • Institutional QI leadership • Online modules (PIMS)	**Part IV[2]:** ABP is enabling new pathways for pediatricians to claim Part IV QI credit for work they are already doing. These pathways are available to physicians who are engaged in QI projects alone or in groups and include a pathway for institutional leaders in quality to claim credit for their leadership. ABP is also allowing trainees (residents and fellows) to "bank" MOC credit for QI activities in which they participate. The pediatricians supervising these trainees also may claim MOC credit for qualifying projects.
Physical Medicine and Rehabilitation (ABPMR) abpmr.org	**Part III:** Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. Released MOC 100, a set of free practice questions pulled directly from the ABPMR exam question banks to help physicians prepare for the exam. There is a separate computer-based secure exam administered at a proctored test center that is required to maintain subspecialty certification. *After the last administration of secure exam in 2020, the exam will be replaced with the Longitudinal Assessment for PM&R (LA-PM&R).*	**Part III[1]:** The Longitudinal Assessment for PM&R (LA-PM&R) is available for all diplomates: • Diplomates receive 20 questions per quarter; after that: between 15 and 18 questions depending on performance (higher performance = fewer questions); • Maximum of 2 minutes to answer each question; • Diplomates can customize their question content; • Diplomates receive immediate feedback indicating whether the answer was correct or incorrect, followed by a critique; and • Available from a desktop or tablet (some features may not work on a phone's web browser). The ABPMR is exploring the use of longitudinal assessment for its subspecialty assessment requirement, but these plans, IT infrastructure, customer service support, and item banks take time to develop. More information on longitudinal assessment

		for subspecialties will be available in the next few years.
	Part IV[2]: Guided practice improvement projects are available through ABPMR. Diplomates must complete: • Clinical module (review of one's own patient charts on a specific topic), or • Feedback module (personal feedback from peers or patients regarding the diplomates clinical performance using questionnaires or surveys). Each module consists of three steps to complete within a 24-month period: initial assessment, identify and implement improvement, and reassessment.	**Part IV[2]:** ABPMR introduced several free tools to complete an IMP project, including a simplified and flexible template to document small improvements and educational videos, infographics, and enhanced web pages. ABPMR is seeking approval from the National Committee for Quality Assurance Patient-Centered Specialty Practice Recognition for Part IV IMP credit. ABPMR is also working with its specialty society to develop relevant registry-based QI activities.
Plastic Surgery (ABPS) abplasticsurgery.org	**Part III:** Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years. Modular exam to ensure relevance to practice. ABPS offers a Part III Study Guide with multiple choice question items derived from the same sources used for the exam. *Following 2021, the computer-based secure exam will be replaced with the internet-based format.*	**Part III:** In April 2020, the continuous certification exam will move to an internet-based testing format: • Diplomate receives 30 questions per year; • Diplomates receive immediate feedback on answers with links to references and educational resources. These are offered with an opportunity to respond again; and • Available on any computer with an internet connection;
	Part IV: ABPS provides Part IV credit for registry participation. ABPS also allows Part IV credit for IMP activities that a diplomate is engaged in through their hospital or institution. Diplomates are asked to input data from 10 cases from any single index procedure every 3 years, and ABPS provides feedback on diplomate data across five index procedures in four subspecialty areas.	**Part IV:** Allowing MOC credit for IMP activities that a diplomate is engaged in through their hospital or institution. Physician participation in one of four options can satisfy the diplomate's Practice Improvement Activity: • Quality Improvement Publication • Quality Improvement Project • Registry Participation • Tracer Procedure Log
Preventive Medicine (ABPM) theabpm.org	**Part III:** In-person, pencil-and-paper, secure exam administered at a secure test facility. MOC exams follow the same content outline as the initial certification exam (without the core portion). *In 2016, new multispecialty subspecialty of Addiction Medicine was established. In 2017,*	**Part III:** In 2019, the ABPM began offering all diplomates remotely proctored MOC exams: • Must be completed by the examinee in a single sitting; • Given in two 50-question sections with an optional 15-minute break between sections;

	Addiction Medicine subspecialty certification exam was administered to diplomates of any of the 24 ABMS member boards who meet the eligibility requirements.	• Diplomates are not allowed to consult outside resources or notes; • Results available on diplomate's dashboard in the physician portal 4 weeks after the completion of the exam; and • Available on smart phone or computer. In 2021, ABPM began piloting a longitudinal assessment program for the Clinical Informatics subspecialty certificate.
	Part IV[2]: Diplomates must complete two IMP activities during each 10-year cycle. One of the activities must be completed through a Preventive Medicine specialty or subspecialty society (ACOEM, ACPM, AMIA, AsMA, or UHMS).	**Part IV[2]:** Partnering with specialty societies to design quality and performance improvement activities for diplomates with population-based clinical focus (e.g., public health).
Psychiatry and Neurology (ABPN) abpn.com	**Part III:** Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. ABPN is developing MOC exams with committees of clinically active diplomates to ensure relevance to practice. ABPN is also enabling diplomates with multiple certificates to take all of their MOC exams at once and for a reduced fee. Grace period so that diplomates can retake the exam.	**Part III:** ABPN implemented a new assessment that allows physicians to select 30-40 lifelong learning articles and demonstrate learning by high performance on the questions accompanying the article in order to earn exemption from the 10-year MOC high-stakes exam.
	Part IV[2]: Diplomates satisfy the IMP requirement by completing one of the following: 1. Clinical Module: Review of one's own patient charts on a specific topic (diagnosis, types of treatment, etc.). 2. Feedback Module: Obtain personal feedback from either peers or patients regarding your own clinical performance using questionnaires or surveys.	**Part IV[2]:** ABPN is allowing Part IV credit for IMP and patient safety activities diplomates complete in their own institutions and professional societies, and those completed to fulfill state licensure requirements. Diplomates participating in registries, such as those being developed by the American Academy of Neurology and the American Psychiatric Association, can have 8 hours of required self-assessment CME waived.

Radiology (ABR) theabr.org	**Part III:** Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. *The secure exam is needed only in limited situations.*	**Part III:** An Online Longitudinal Assessment (OLA) model was implemented in place of the 10-year traditional exam. OLA includes modern and more relevant adult learning concepts to provide psychometrically valid sampling of the diplomate's knowledge. • Diplomates must create a practice profile of the subspecialty areas that most closely fit what they do in practice, as they do now for the modular exams; • Diplomates will receive weekly emails with links to questions relevant to their registered practice profile. • Questions may be answered singly or, for a reasonable time, in small batches, in a limited amount of time. • Diplomates receive immediate feedback about questions answered correctly or incorrectly and will be presented with a rationale, critique of the answers, and brief educational material. *Those who answer questions incorrectly will receive future questions on the same topic to gauge whether they have learned the material.*
	Part IV[2]: Diplomates must complete at least one practice QI project or participatory QI activity in the previous 3 years at each MOC annual review. A project or activity may be conducted repeatedly or continuously to meet Part IV requirements.	**Part IV[2]:** ABR is automating data feeds from verified sources to minimize physician data reporting. ABR is also providing a template and education about QI to diplomates with solo or group projects.
Surgery (ABS) absurgery.org	**Part III:** Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. Transparent exam content, with outlines, available on the ABS website and regularly updated. ABS is coordinating with the American College of Surgeons and other organizations to ensure available study materials align with exam content.	**Part III:** In 2018, ABS began offering shorter, more frequent, open-book, modular, lower-stakes assessments required every 2 years in place of the high-stakes exam: • Diplomates will select from four practice-related topics: general surgery, abdomen, alimentary tract, or breast; • More topics based on feedback from diplomates and surgical societies are being planned;

	The secure exam is no longer offered for general surgery, vascular surgery, pediatric surgery, surgical critical care, or complex general surgical oncology.	• Diplomates must answer 40 questions total (20 core surgery, 20 practice-related; • Open book with topics and references provided in advance; • Individual questions are untimed (with 2 weeks to complete); • Diplomate receives immediate feedback and results (two opportunities to answer a question correctly); and • Diplomates can use their own computer at a time and place of their choosing within the assessment window. The new assessment is available for general surgery, vascular surgery, pediatric surgery, or surgical critical care with other ABS specialties launching over the next few years.
	Part IV[2]: ABS allows ongoing participation in a local, regional, or national outcomes registry or quality assessment program, either individually or through the Diplomate's institution. Diplomates must describe how they are meeting this requirement—no patient data is collected. The ABS audits a percentage of submitted forms each year.	**Part IV[2]:** ABS allows multiple options for registry participation, including individualized registries, to meet IMP requirements.
Thoracic Surgery (ABTS) abts.org	**Part III:** Remote, secure, computer-based exams can be taken any time (24/7) that the physician chooses during the assigned 2-month period (September-October) from their home or office. Diplomates must pass the exam once every 10 years. Modular exam, based on specialty, and presented in a self-assessment format with critiques and resources made available to diplomates.	**Part III:** ABTS developed a web-based self-assessment tool (SESATS) that includes all exam material, instant access to questions, critiques, abstracts, and references.
	Part IV[2]: ABTS diplomates must complete at least one practice QI project within 2 years, prior to their 5-year and 10-year milestones. There are several pathways by which diplomates may meet these requirements: individual, group or institutional. A case summary and patient safety module must also be completed.	**Part IV[2]:** *No changes to report at this time.*

Urology (ABU) abu.org	**Part III:** Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years. Clinical management emphasized on the exam. Questions are derived from the American Urological Association (AUA) Self-Assessment Study Program booklets from the past five years, AUA Guidelines, and AUA Updates. Diplomates required to take the 40-question core module on general urology and choose one of four 35-question content specific modules. ABU provides increased feedback to reinforce areas of knowledge deficiency.	**Part III:** In 2021, ABU began piloting a new assessment format that combines shorter more frequent assessments with article-based assessments over a 5-year cycle. Diplomates achieving a score of > 60% correct during the Knowledge Reinforcement (years 1 and 3), and ≥ 80% correct during the Knowledge Exposure (years 2 and 4) are not required to take the year 5 Knowledge Assessment but may participate if desired. If the Knowledge Assessment is not taken, learning in year 5 would be self-directed. The existing computer-based secure knowledge assessment is based on Criterion referencing, thus allowing the identification of two groups, those who unconditionally pass the knowledge assessment and those who are given a conditional pass. The group getting a conditional pass will consist of those individuals who score in the band of one standard error of measurement above the pass point down to the lowest score. That group would be required to complete additional CME in the areas where they demonstrate low scores. After completion of the designated CME activity, they would continue in the Lifelong Learning process and the condition of their pass would be lifted.
	Part IV[2]: Completion of Practice Assessment Protocols. ABU uses diplomate practice logs and diplomate billing code information to identify areas for potential performance or QI.	**Part IV[2]:** ABU allows credit for registry participation (e.g., participation in the MUSIC registry in Michigan and the AUA AQUA registry). Another avenue to receive credit is participation in the ABMS multi-specialty portfolio program (this is more likely to be used by Diplomates who are part of a large health system, e.g. Kaiser, or those in academic practices).

*The information in this table is sourced from ABMS member board websites and is current as of January 20, 2022.
[1]Utilizing CertLink®, an ABMS web-based platform that leverages smart mobile technology to support the design, delivery, and evaluation of longitudinal assessment programs, some of which launched in 2017-2018. More information is available at: https://www.abms.org/initiatives/certlink/member-board-certlink-programs/ (accessed 1-13-20).
[2]Participates in the ABMS Portfolio Program™ which offers an option for organizations to support physician involvement in quality, performance and process improvement (QI/PI) initiatives at their institution and award physician IMP credit for continuing certification.

APPENDIX B:
MEMBER BOARD TEMPORARY CHANGES DUE TO COVID-19**

American Board of	Initial Certification	Continuing Certification
Allergy and Immunology	1. ABAI will give initial certification exam candidates the option to take the exam in 2021 without the need to reapply or pay additional fees. 2. ABAI will enable a one-time increase from 8 to 10 weeks for maximum time away from training requirement without a formal exception to policy request from the program director for 2020 and 2021 graduates. 3. ABAI will support the inclusion of COVID-19 education and clinical activities in fellowship curricula as determined by the ACGME Allergy-Immunology Review Committee. 4. Extending the board eligibility window by one year from 7 to 8 for all allergist-immunologists meeting eligibility requirements for the 2020 initial certification exam regardless of whether a candidate is registered for the exam.	1. Extending the expiration date for certificates expiring in 2020 to 12/31/2021. No diplomate will lose their certification this year or next as a result of the COVID-19 crisis. 2. Extending the deadline for all individual MOC requirements (parts I, II, III, and IV due in 2020 to 12/31/2021. 3. Extending 2020 MOC fee deadline to 12/31/2021 allowing for combined 2020/2021 fee submission without penalty or impact continuing certification status. 4. ABAI will provide expedited certification status confirmation to credentialing bodies as diplomates adapt in person and telemedicine practices.
Anesthesiology	1. All applied exams have been cancelled. Trainees will not be adversely affected. The ABA is working to create a virtual exam. 2. Time spent by residents in quarantine will be counted as clinical hours. 3. Residents who miss training due to contracting COVID-19 may request an additional absence from training. 4. ABA executing ADVANCED Exam as scheduled in July. 5. ABA has voted to move forward with a virtual administration of the APPLIED Examination in the spring of 2021. While it remains the intention to assess all 2020 and 2021 candidates by the end of 2021, 2020 APPLIED Exam candidates will be given priority and will receive their exam appointment for the first half of the year no later than November. Time zones will be taken into consideration and accommodated. The Board will decide in early 2021 if the APPLIED Exams will continue virtually during the second half of 2021 based upon the state of the pandemic. In order to assess as many candidates as possible in 2021, candidates will not be able to select their exam appointment.	The ABA have already begun to add COVID-19 questions to MOCA Minute and are working to rapidly add more questions that speak to the unique needs of this pandemic. As with all MOCA Minute questions, the new COVID-19 related items include links to learning resources that physicians may find useful.

Colon and Rectal Surgery	1. It is up to the program director with input from the CCC to assess procedural competence of an individual trainee as one part of the determination of whether that individual is prepared to enter autonomous practice. 2. Case log minima will not be waived by the RRC, but case logs will be judiciously considered in light of the impact of the pandemic on that program. 3. Regarding certification by the ABCRS, all application deadlines remain in place. The board utilizes a number of criteria to admit a candidate for the written examination. The program director attestation and case logs will be reviewed with consideration given to the issues we are facing. The oral examination scheduled for September. 4. With a decrease in elective surgeries during this time, residencies/fellowships may be extended. The ACGME accredits programs. It does not certify individuals. What an extension of residency/fellowship would mean for a given individual in terms of the board certification process can only be answered by the appropriate certifying board. 5. The oral exam has been deferred to March 2021.	1. Due to the unprecedented pandemic creating obstacles for Diplomates, there is an option built into the Continuing Certification program. If the Diplomate has successfully answered 70% of the questions over four years, Diplomates can take the fifth year off from answering any question. Diplomates may request off a quarter or more without penalty and those quarters will be added to the fifth year. 2. Requests to take a quarter off may be made during that quarter for a maximum of four quarters.
Dermatology	1. The ABD will grant an extra year of eligibility for board certification to residents graduating in 2020. Instead of the normal 5 years of eligibility, residents will have 6 years to pass the exam. 2. Any board-eligible candidate currently in the traditional certification pathway may switch to the new certification pathway. This involves passing 4 CORE Exam modules, which can be taken via online proctoring, then passing the APPLIED Exam, which can be taken at a local Pearson VUE test center. The first possible date to complete all portions of this new exam is July 2021. Once in the new pathway, there is no option to switch back to the traditional pathway. 3. The traditional certification pathway exam is planned for administration via Pearson VUE in both 2021 and 2022. After 2022, everyone in the traditional certification pathway who has not passed the Certification Exam must transfer to the new pathway and pass the CORE and the APPLIED Exams.	1. ABD offering diplomates in the last year of their cycle the option to enroll in CertLink® in lieu of taking the traditional MOC Exam. 2. ABD reduced the question load from four segments to two and extended the period for completion for diplomates participating in CertLink®. Diplomates will have the option of designating one of these segments as a "time off" period. 3. Diplomates scheduled to take the MOC exam before the end of 2020 had two options: either participate in CertLink® or take the traditional exam with a deadline of June 2021. 4. The self-assessment requirement for 2020 is deferred until the end of 2021. 5. Practice improvement exercises due in 2020 can be deferred until the end of 2021.

Emergency Medicine	1. ABEM cancelled the May ConCert exam. It will now be available in an online-open book format for two three-week periods during 2021 and 2022. 2. ABEM will accommodate a 2-week quarantine period for residents without affecting board eligibility. 3. ABEM does not define what constitutes 44-week training programs. Program directors and the ACGME define those requirements. ABEM does not define, police, or regulate clinical hours or other forms of educational activity. ABEM strongly supports asynchronous learning as part of training during any time at which a candidate might be quarantined. 4. ABEM has relaxed deadlines and simplified logistics for recent residency graduates who are pursuing initial certification in Emergency Medicine and a subspecialty. The new deadline for completing certification requirements is June 30, 2021. Subspecialty certification deadline is now December 31, 2021 for: Anesthesiology Critical Care Medicine, Hospice and Palliative Medicine, Internal Medicine-Critical Care Medicine, Pain Medicine, and Sports Medicine. 5. The virtual Oral Exam will be piloted and then fully implemented in 2021. Candidates who were scheduled for the Oral Exam in 2020 will be the first to be scheduled for the virtual Oral Exam.	1. ABEM extended the grace period for certification by six months for those physicians whose certificates expire in 2020. The new deadline for meeting certification requirements is July 2021. 2. Beginning in spring 2021, ABEM-certified physicians will be able to meet continuing certification requirements by completing four MyEMCert modules (online and open book, approximately 50 questions each) instead of taking the ConCert Exam. The switch to MyEMCert will emphasize relevant content, save emergency physicians time and money, and better accommodate their busy schedules. ABEM will no longer offer ConCert after 2022. Starting in 2021, ABEM will move to a 5-year certification period for physicians when they next recertify. Specifically, any certificate awarded or renewed in 2021 and after will be for a 5-year duration. It is important to note the move from a 10-year to 5-year certification length will not increase total requirements or increase the cost to stay certified. This change is in response to physician requests to use MyEMCert to recertify sooner. By moving to a 5-year certification period, physicians will now be able to use MyEMCert to recertify starting in 2021. As physicians move to a 5-year certification period, ABEM will also move to an annual fee structure. We recognize this change affects physicians differently based on where they are in their current continuing certification process. ABEM has set a cap on fees paid by physicians so no physician will pay more than $1,400 to renew their certification. This approach levels the costs associated with certification. ABEM has identified physicians who have exceeded this fee cap and will issue a refund.
Family Medicine	1. ABP cancelled initial certification exams, which includes the Adolescent Medicine initial certification exam necessary for candidates for Adolescent Family Medicine. ABFM reached out to those physicians and is monitoring what ABP does before making any decisions. 2. ABFM relies on Program Director attestation that the resident has completed all ACGME requirements for training and that the program's CCC agrees that the resident is ready for autonomous practice. Specifically important for board eligibility are that the resident has completed 1,650 in person patient encounters and has had	1. ABFM extended the 2020 FMCLA quarterly deadlines by 3 months each. 2. ABIM cancelled their Spring exam, which includes the Geriatric Medicine continuing certification exam necessary for diplomates specializing in Geriatric Family Medicine. There was a 2nd administration of that exam in the Fall. 3. Diplomates with a stage ending in 2020 will have a one-year extension to complete stage requirements. 4. Physicians due to take their examination in 12/31/2020 will have the option for an additional year to complete the examination requirement while remaining certified.

	40 weeks of continuity practice in each year of training. For COVID accommodations, ABFM is allowing for the 1,650 visits to be either in person or virtual and accepting Program Director attestation on any modifications of rotation requirements based on ACGME's direction. Additionally, ABFM has stated that any time away from residency related to a resident requiring quarantine for COVID exposure or personal treatment for COVID will not count against the time away from training/family leave policy.	5. Diplomates who participate in certification activities this year will have the option to defer paying certification fees due to financial hardship until next year. 6. Diplomates in the 2021 cohort of FMCLA had their meaningful participation requirement in the first year reduced from 80 completed items to 50 items. 7. A new COVID-19 Self-Directed PI activity provides a mechanism for meeting the Performance Improvement (PI) requirement by reporting on the unprecedented and rapid changes they had to make as a result of the pandemic. 8. Any board-eligible family physician with an eligibility end date in 2020, or anyone participating in the re-entry process with an end date in 2020, will have an additional year to obtain their certification. 9. Any Diplomate who also holds a Certificate of Added Qualification with an examination deadline in 2020 will have the option for an additional year to complete the examination requirement.
Internal Medicine	1. Any absence related to COVID-19 will not affect board eligibility for residents. 2. ABIM has decided to cancel all Spring assessments, including the Critical Care Medicine Knowledge Check-in. ABIM will extend the assessment deadline so that rescheduling does not reduce the number of opportunities to pass the exam prior to the deadline. 3. ABIM unable to print Specialty certificates for physicians due to the Philadelphia stay at home order. ABIM encourages physicians to find their digital badge on the Physician Portal. No proof or documentation is needed if you schedule for a future date. 4. The IM Certification exam has been cancelled. Candidates will receive a $150 credit and can reschedule their exam for the following dates:	1. ABIM is extending deadlines for all Maintenance of Certification (MOC) requirements to 12/31/22. 2. Diplomates can reschedule their exam at no additional cost. 3. There will be no negative impact to certification status due to cancellation of Spring assessments. No one will lose their certification status if they are not able to complete a requirement this year. Any physician who is currently certified and has a Maintenance of Certification (MOC) requirement due in 2020—including an assessment, point requirement, or attestation—will now have until the end of 2021 to complete it. Physicians currently in their grace year will also be afforded an additional grace year in 2021. 4. ABIM is working with ACCME to ensure their virtual education offerings that earn CME also count for MOC points.

Medical Genetics and Genomics	1. Time spent in quarantine can count as clinical hours for residents as long as the program director defines continued learning and training activities that can be accomplished and documented. 2. Extended absences for those who contract COVID-19 will be considered on a case-by-case basis. 3. Any required rotation experiences may require an extension of training which will be determined by the program director. 4. Telemedicine sessions may be included in logbooks for both clinical and laboratory trainees as long as appropriate learning objectives have been fulfilled. 5. Laboratory Fellows: The number of cases per time period may be modified such that up to 35 cases may be collected in a given month for clinical biochemical genetics and up to 40 cases may be collected in a given month for laboratory genetics and genomics. 6. LGG Mentored Cases: The ACMG is working with the faculty mentors in each pathway on a detailed schedule. Registered participants sent link via Zoom meeting and assigned to breakout groups. The groups rotate with the mentors to go through the cases. 7. The requirement for the ACMG hands-on short course has been modified for the 2021 Examination cycle. If you could not participate in the 2020 virtual course, you will be able to take the course offered in April 2021 at the ACMG annual meeting to meet requirements for the 2021 Certification Examination. You will have to submit to the ABMGG proof of course registration before the March 10, 2021, deadline and your certificate of attendance after the course is completed.	1. The total number of required CME is reduced from 25 to 15 hours. 2. LGG Alternative Pathway Logbook Requirements: The ABMGG continues to monitor the impact of COVID-19 pandemic and urges you to prioritize your safety and that of your colleagues. To accommodate the potential impact of the pandemic on the LGG Alternative Certification Pathway, the ABMGG will allow the following adjustments to logbook requirements for the 2021 examination only: • The deadline for logbook submission is now May 10, 2021. • Up to 30 cases may be collected in a given week. • If a diplomate is unable to complete all logbook requirements by May 10, 2021, up to 15% fewer total cases may be submitted. However, the logbook must still reflect substantive experience in ALL required categories and be reviewed by the supervising geneticist. In such instances, a letter of explanation from the diplomate and the supervising geneticist must be included with the logbook submission. 3. ABMGG Board of Directors has extended the alternative pathway through 2025 to allow diplomates more time to gain their required training and be able to sit the exam in 2025. Note that all requirements for training remain the same.
Neurological Surgery	1. The ABNS Primary exam for self-assessment is not considered mandatory. Those who schedule to take the 2020 self-assessment may choose to wait until next year to take the exam.	
Nuclear Medicine	1. ABNM modified their leave policy to include 2 weeks of quarantine. 2. If a resident exceeds an 8-week absence, program directors will need to have a plan approved by ABNM to compensate for lost educational time. 3. Candidates for the ABNM certification examination are also required to be certified in advanced cardiac life support (ACLS). The American Heart Association	

	is allowing a 60-day extension of ACLS instructor cards beyond the renewal date and recommends that employers and regulatory bodies extend provider cards 60 days beyond renewal date. The ABNM is adopting this recommendation: ACLS certification – 60-day extension beyond renewal date of current provider cards. 4. If trainees do not meet these modified requirements, program directors will be required to provide the ABNM with an educational plan and request for exemption that will be considered on a case-by-case basis.	
Obstetrics and Gynecology	2021 Specialty CE: • Application Fee: Candidate can request a refund if request is based on inability to take exam due to COVID-19. Or candidate can choose to roll this fee into 2022 exam year. • Application Deadline: Application deadline is extended to June 21, 2021 (instead of May 21). Late fee deadlines are extended out by one month (1st late fee applies 5/4 instead of 4/2; 2nd applies 6/4 instead of 5/4). • Case List and Exam Fee Deadlines: Deadlines are extended to August 31, 2021 (instead of August 16) and late fee deadline is extended to August 16, 2021 (instead of August 2). Case lists requirements have been reduced. Increasing the amount of leave time allowed during case collection from 12 to 24 weeks. 2022 Subspecialty CE: • Application fee: Candidate can request a refund if request is based on inability to take exam due to COVID-19. Or candidate can choose to roll this fee into 2022 exam year. • Application deadline: Application deadline is extended to July 31, 2021 (rather than June 30). Late fee deadlines are extended out by one month (1st late fee applies 7/7 instead of 6/4; 2nd applies 7/20 instead of 6/18). 2021 Specialty and Subspecialty QEs: • Applications and processes already completed for the 2021 QEs. No changes. NOTE regarding FLS Certification: Requirement to complete by Qualifying Exam date is lifted. Completion and	▪ All articles released within ABOG's MOC Part II Lifelong Learning and Self - Assessment in January and May this 2021 MOC year will be designated as incentivized. ▪ Each incentivized article has eight questions to complete (instead of the usual four). ▪ ABOG Diplomates will read half the number of required articles (15 instead of the usual 30) but still answer a total of 120 questions to complete the requirement for 2021 MOC year. ▪ There will be no articles released in August as Diplomates will be able to complete their article requirements using the incentivized process. ▪ This incentivization applies to both OB GYN specialists and subspecialists. ▪ Diplomates who participate in the 2021 MOC year will be automatically granted Part IV IMP credit in recognition for the COVID-19 practice improvement that they will continue to do this year during the evolving pandemic. ▪ If Diplomates have completed the IMP requirement prior to this ABOG action, ABOG will apply the credit towards their 2022 MOC year. ▪ The deadline to take and pass the ABOG MOC Re-Entry Exam will be extended through June 30, 2021, to allow physicians to have more time to take and pass the exam. ▪ There will be additional COVID-19 articles included in the 2021 MOC year, especially regarding COVID-19 vaccines.

	submission of documentation (FLS certificate) required to be eligible to submit application for Certifying Examination. Subspecialty Training • Completion of Research/Thesis: Fellows can finalize research and theses after completion of training, provided Program Director (PD) contacts ABOG to request the extension. The PD must include how long they are requesting the research be extended and a new estimated completion date for review by the Credentials Subcommittee. Typically, research and theses to be presented during the Certifying Examinations are required to be completed by the end of fellowship training.1. As an alternative to the May 11 date, ABOG is offering affected candidates (lost seats, other issues) the option of taking a proctored paper examination. Additional Notes: • Time spent in quarantine will count as clinical experience. Residents can coordinate with their program directors to arrange academic, research, and study activities. • Time spent taking care of a family member, partner, or dependent in COVID-19 quarantine will count as clinical experience. This is a local decision based on local program requirements. • Eligibility period for certification will be extended by one year for any resident, fellow, residency graduate, or active candidate who requests such an extension due to the COVID-19 crisis. • ABOG is increasing the allowed weeks of leave from 12 to 24 weeks. This includes medical leave, maternity leave, caregiver leave, vacation, furloughs, and other situations. • Candidates may list COVID-19 patients if they were primarily responsible for their inpatient or outpatient care. • As part of its COVID-19 response, ABOG has established a policy extending eligibility by two years for all candidates currently eligible for initial OB GYN and subspecialty certification. This policy applies to physicians who have graduated from residency and/or fellowship and whose eligibility for certification has not	

	previously expired or whose eligibility was previously reestablished.	
Ophthalmology	1. Oral exams have been cancelled. After surveying the 650 candidates scheduled to take the oral exam, ABOp has decided to move to a virtual oral exam. ABOp intends to preserve the original case-based format of the face-to-face oral examination when they shift to a virtual administration (VOE20). Beta testing is going well. 2. All exam fees are transferable to the next exam administration and each candidate's board eligibility window will be extended accordingly. 3. Seven-year board eligibility window following graduation from residency will be extended by one year if you are unable to sit for the VOE20. 4. ABOp has an informational video for candidates concerning what to expect from the Virtual Oral Examination.	1. ABOp diplomates are actively looking for ABOp MOC content and resources to use during this period of time when many of them are unable to see non-emergency patients. 2. Many of our colleagues requested that we release Quarterly Questions content ahead of schedule so that they can use unanticipated downtime productively. The second quarter's installment, originally slated for release on April 1st, was distributed by email on March 24th. 3. With the help of many dedicated ophthalmologist volunteers, we released new COVID-19-related article-based material for Quarterly Questions on March 31st. 4. Several dozen diplomates have embraced a new option for creating Improvement in Medical Practice projects that are designed to improve the care of patients with COVID-19 and to protect the health of ophthalmologists and their staff. Completion earns credit for one Improvement in Medical Practice activity. 5. Newly approved CME activities focused on

		the COVID-19 pandemic are available on the CME Finder Menu. These activities may be counted toward the ABO's requirement for lifelong learning and self-assessment. 6. Extensions may be requested by those whose certificates expire on December 31, 2020, to allow additional time to complete Maintenance of Certification (MOC) activities.
Orthopaedic Surgery	1. ABOS rules and procedures changed to allow for 6 weeks of time away from education per year of residency. 2. Candidates for the 2021 ABOS Part II Oral Examination must collect and submit all consecutive surgical cases that they perform as primary surgeon beginning January 1, 2020, for a minimum of six consecutive months. On July 1, 2020, if the Candidate has reached 250 surgical cases, they can cease collecting. If not, the Candidate will continue to collect cases until they have entered 250 consecutive surgical cases, or until September 30th, whichever comes first. 3. The ABOS is transitioning their oral exam to an online, case-based exam. Details about the exam are in the "other" column.	ABOS will make ABOS WLA available to diplomates who did not start the program last year. Diplomates who have ABOS Board Certification expiration dates between 2019 and 2020 and who did not participate in the 2019 ABOS WLA, may now participate beginning this year.
Otolaryngology - Head and Neck Surgery	1. The October in-person exam administrations have been cancelled. ABOHNS is working to develop a virtual exam format for all exams, including the first virtual oral examination. They plan to administer these exams in October or November to Neurotology subspecialty candidates. ABOHNS will use that same format to administer the Otolaryngology-Head and Neck Surgery oral certifying exam and are currently working toward a January 2021 tentative date. 2. For the PGY-1 residents for the 2019-2020 academic year, the ABOHNS expects a minimum of 3 months of otolaryngology rotations and 3 months of non-otolaryngology rotations chosen from amongst the options described in the Booklet-of-Information dated June 2019. For the remaining 6 months, the ABOHNS will allow flexibility for the rotations at the discretion of the residency program director if necessary to ensure best care for patients with COVID-19. If changes need to be made to a resident's rotations that	CC diplomates who expired in June 2020 – Diplomates given option to defer to May 2021 exam and certification extended until that time.

	result in the usual requirements not being met, the Residency Program Director needs to inform the Board at the conclusion of the resident's PGY-1 year. No rotations will need to be made up as long as the minimum requirements described above are met. 3. Clinical time caring for patients with COVID-19 will be counted toward the training requirements for Board Eligibility. At the conclusion of the academic year, the residency program director with input from the CCC will still be required to decide whether a resident has acquired/demonstrated the knowledge, skills, and behaviors necessary to advance to the subsequent PGY-year or graduate from residency and enter autonomous practice if in the ultimate year. If a determination is made that a resident's training needs to be extended based on effects of the COVID pandemic on their Otolaryngology-Head and Neck Surgery training/experience, then the ABOHNS requests being proactively informed by the program director of this decision as soon as feasible. 4. If an Otolaryngology-Head and Neck Surgery resident requires a 2-week self-isolation/quarantine, this time will not count toward the 6-weeks allowed leave time for the PGY-year if the program arranges for the resident to complete academic/study activity during that time. The Residency Program Director will need to provide a written description of the academic/study activity to the ABOHNS. Extended absences (> 2 weeks) for residents that contract and require care for COVID-19 will be considered on a case-by-case basis. 5. Oral Certifying Exam – Spring 2020 postponed, moving to virtual exam in Feb 2021 6. Board Eligibility extended by 1 year for all WQE candidates – Candidates were given the option to defer or to take the exam.	

Pathology	The American Board of Pathology will allow the following reasons for absence from on-site training to count as clinical training if the resident/fellow arranges with their program director to continue learning and training activities. Residents/fellows should keep a daily log of time spent and a brief description of the activities. The Program Director must attest that the overall competency of the resident/fellow at the completion of training was not adversely affected by the absence. • COVID-19 illness or exposure • Mandated quarantine • Shelter in place/shelter at home directives • Self-imposed isolation because of significant underlying health issues • Care for a sick or quarantined immediate family member • Providing childcare due to school/childcare closures • Volunteering or being assigned to other institutional or clinical duties The ABPath will consider additional requests for absences on a case-by-case basis from residents who miss training for an extended period of time for other reasons. Due to the ongoing health risks of COVID-19, the ABPath has been working diligently to administer this year's certification exams remotely. ABPath is making a one-time exception to policy that will allow candidates who have completed ACGME subspecialty fellowship training to apply for and take 2020 Subspecialty exams prior to passing the primary exam. Candidate subspecialty examination results will be placed in a Withhold Results status. The results of their subspecialty exam will not be released to you until you achieve primary certification. Candidates will have until 2022 (2 years) to become certified in AP and/or CP. If they do not achieve primary certification before the end of 2022, the subspecialty examination results will be declared null and void. Candidates will be required to retake the subspecialty exam again and only after you have achieved primary certification. If their period of board eligibility for primary certification ends prior to 2022, their subspecialty examination results will become null and void at that time. 2020 candidates for certification have already completed their	1. At this time, ABPath Continuing Certification requirements, except for ABPCL, have not changed. 2. The 2021 Subspecialty and Fall Primary Exams (AP and CP) will be administered using Pearson VUE Professional test centers 3. The American Board of Pathology (ABPath) is announcing two changes to the Continuing Certification (CC) Program that have been approved by the American Board of Medical Specialties. Beginning in 2021, the ABPath will no longer require: • Self-Assessment Modules (SAMs) for Part II Lifelong Learning of the CC program • a Patient Safety Course. The "SAMs" requirement was developed by ABPath to ensure that at least 20 of the required 70 CME credits had a self-assessment activity. Since ACCME accreditation requires that the CME provider analyzes changes in learners (competence, performance, or patient outcomes) achieved as a result of the overall program's activities/educational interventions, having a SAMs requirement is no longer necessary and is burdensome for diplomates and CME providers. ABPath's CertLink® longitudinal assessment has been approved by ABMS as a permanent change to our CC program in 2021 and this provides diplomates with self-assessment of medical knowledge as well. Diplomates will still be required to complete and report a minimum of 70 AMA PRA Category 1 CME credits for each two-year CC reporting period. Participation in Patient Safety CME will be encouraged, but no longer required. 4. The American Medical Association (AMA) has recently announced added enhancements to their online education portal AMA Ed Hub™ aimed at offering physicians a centralized location for finding, earning, tracking, and reporting continuing medical education (CME) and other education on a wide range of clinical and professional topics. The platform now allows physicians who are board-certified with the American Board of Pathology (ABPath) to have their credits automatically reported to ABPath.

	50 autopsies. The ABPath recognizes that some 2021 candidates may have difficulty achieving 50 autopsy cases. We will address this when applications become available for them in the fall.	
Pediatrics	1. Residents should address training absences with their program director. 2. If candidates are unable to reschedule their exam, they can request a refund of the exam fees. If a candidate chooses not to take the exam this year, their eligibility will not be extended. 3. There will be a one-year extension for general pediatrics candidates who cancel their certification exam due to COVID-19. The same extension applies to all candidates taking the subspecialty exam. 4. Prometric has rescheduled a small number of subspecialty exam candidates from test centers due to COVID-19 social distancing guidelines.	1. Prometric has suspended their proctored MOC exams, and they are reaching out to individuals with testing appointments in order to reschedule. 2. No pediatrician will lose their ABP certification because of the extraordinary patient care pressures associated with this pandemic. 3. The ABP will recognize board certified pediatricians for their COVID-19 related contributions to the MOC program. 4. Diplomates unable to participate in MOC activities or MOCA-Peds because of the pandemic; it will not jeopardize their certificate or ability to re-enroll in MOC. 5. ABPeds is actively working on ways to accommodate pediatricians due to enroll in 2021 who continue to face significant financial hardship through the end of the year. In the meantime, all pediatricians should be aware of the smaller ($280 for those with one certification) annual payment option for MOC. 6. For those pediatricians who have already completed their Part 2 and Part 4 activity requirements for their MOC cycle ending in 2020, thank you! We will award 25 Part 2 points and 25 Part 4 points for COVID-19-related learning and improvement in January 2021 to count toward your next cycle.

Physical Medicine and Rehabilitation	1. Exam applications for Brain Injury Medicine, Neuromuscular Medicine, Pediatric Rehabilitation Medicine, Spinal Cord Injury Medicine, and Sports Medicine have been extended. 2. ABPMR understands that changing the date of the exam may introduce scheduling conflicts, but it is extremely important that candidates make every attempt to take the exam in September. If too many 2020 candidates delay taking the exam until next year, it is likely that the ABPMR will need to place a cap on 2021 Part II Examination applications, potentially turning applicants away for the first time in our history. 3. ABMPR urges candidates to continue exam preparation efforts. We will be releasing additional vignette and roleplay videos over the next few weeks to help candidates prepare. 4. Candidates need to wait for announcements about subspecialties. If they had plans to take the Part II Examination and a subspecialty examination consecutively in 2020, we realize postponing Part II presents timing issues for some of these exams. We are currently evaluating options and will make announcements when more information is available. In some cases, it may be necessary to defer taking the subspecialty exam to the next administration. 5. ABPMR will administer a virtual certification oral exam in the fall. 6. After hearing reports that candidates were unable to find seats at a testing center near them, the American Board of Anesthesiology (ABA, the administering board for the Pain Medicine Examination), offered to extend the Pain Medicine Examination date to a 2-week window for ABPMR candidates. We quickly agreed; all ABPMR candidates can now schedule on any day in that two-week window. Candidates should reach out to the ABA for more information. 7. Through June 30, 2021 — Up to 30 additional working days spent away from training due to mandated quarantine, institutional restriction, or illness directly related to COVID-19 will be permitted provided the trainee is otherwise competent, per the Program Director, at the conclusion of training. These 30 working days are in addition to overall	1. No ABPMR diplomate will lose certification or experience a status change due to not being able to complete an MOC requirement in 2020. Any outstanding MOC requirements on primary certificate at the end of 2020 will carry over into the first 5-year continuing certification cycle, giving an extended timeline of 2025. 2. ABPMR will give full carryovers for all 2020 ABPMR computer-based exams. 3. In order to maintain a reduced burden on diplomates during the pandemic, the next LA-PM&R 'quarter' will extend from August through December, with only 20 questions for participants to answer for the remainder of the year. All diplomates' quotas and scoring will be adjusted automatically.

	leave time and will not result in a mandated increase to training time.	
Plastic Surgery	1. Candidates taking WE in 2020 were allowed to shift to 2021 w/o penalty. 2. Alternate dates for scheduling the WE were offered, 3. Required number of cases for candidate case logs were reduced, 4. Certain documentation requirements for case lists were eliminated, 5. OE exam was switched to a virtual exam for 2020 and 2021, 6. Eligibility will be extended for any candidate who could not schedule for the WE in 2020.	1. ABPS has given every Diplomate who needed to report CME in 2020 an extension to 2021. 2. The self-assessment exam and the practice improvement activities remain the same. The practice improvement activity can use cases from as far as three years back. 3. All self-assessment exams including prior years that still need to be completed are available online.
Preventive Medicine	ABPM will make accommodations for early graduations or truncated residency and/or fellowship training for physicians who would otherwise qualify to sit for this year's ABPM initial Certification Exam.	1. Effective as of April 1, 2020, and continuing through December 31, 2022, Diplomates who meet the qualifications below will not be required to complete the Transitional MOC Part 2 (CME), Part 4 (Improvement in Medical Practice) or the Patient Safety Course (PSC) requirements. ABPM will recognize these qualified Diplomates as fully participating in MOC through the remainder of the ABPM's Transitional MOC Period. To qualify for this waiver of Part 2, Part 4 and PSC requirements, Diplomates must possess current, unexpired Certification in at least one ABPM Specialty or Subspecialty and must by December 31, 2020. 2. Diplomates with ABPM Certificates expiring between August 1, 2020, and January 31, 2023, and who have; (I) taken and passed the MOC Exam prior to the expiration date on the Diplomate's Certificate and, (ii) by the December 31, 2020, deadline, have registered their Diplomate account on the ABPM's Physician Portal, will be deemed to be fully compliant with the Transitional MOC requirements. 3. Diplomates with ABPM Certificates

		expiring on or after February 1, 2023, and who have, by the December 31, 2020, deadline, registered their Diplomate account on the ABPM's online Physician Portal, need take no further action and shall be deemed to be fully compliant with all Transitional MOC requirements. 4. While not required, Diplomates who complete a Part 4 activity between February 1, 2020, and December 31, 2022, will receive credit toward the first Improvement in Medical Practice requirement (or its equivalent) of ABPM's Continuing Certification Program which is currently scheduled to launch in April of 2023. 5. Diplomates who do not qualify for the waiver by registering their Diplomate account on the ABPM's Physician Portal by the December 31, 2020, deadline will be required to complete all Transitional MOC requirements as set forth on the ABPM website. 6. Additionally, the ABPM has partnered with its specialty societies to provide a list of free online courses on COVID-19. Diplomates who complete these courses may request credit towards the ABPM's Transitional MOC Part 2 requirements using the online attestation found in the Physician Portal.
Psychiatry and Neurology	1. All late payment fees have been waived. 2. If any candidate cannot make it to a Pearson Vue testing center within 50 miles of their location, ABPN will assist them in scheduling their exam date. 3. ABPN has decided to extend its current board eligibility policy through June 30, 2021. Program Directors can be assured that the Board will continue to follow their lead with respect to whether or not a particular resident has completed the specific training needed for graduation. The ABPN will continue to be flexible with respect to senior residents as long as the Program Director agrees. 4. Through June 30, 2021, the ABPN will continue to accept virtual CSEs completed via a remote conferencing platform such as Zoom for all psychiatry and neurology residents as part of the credentialing requirements to sit for an ABPN initial certification exam.	1. The ABPN and the American Academy of Neurology (AAN) have collaborated to provide ABPN diplomates complimentary access to American Academy of Neurology (AAN) 2019 meeting programming. Through an educational grant from the ABPN to the AAN, ABPN diplomates now have free access to both the AAN Annual Meeting on Demand 2019 program and the NeuroSAE 2019 Annual Meeting Edition. 2. For diplomates whose specialty or subspecialty certificates would have expired in 2020, we will defer the 2020 CC/MOC exam requirement for 1 year until December 31, 2021. Certificates expiring in 2020 will be extended to the end of 2021. This extension does not include certificates that lapsed prior to February 1, 2020. 3. For diplomates currently in the CC program, ABPN will not change a certification status negatively even if there are insufficient or incomplete activities (CME, Self-Assessment or PIP) recorded in Physician Folios at the end of 2020. Incomplete CC program activities will be deferred until the end of 2021. 4. Extending deadlines for all current 2020

		and 2021 Continuing Certification Program examination and activity requirements until Dec. 31, 2022. 5. The APA and ABPN have collaborated to provide diplomates with complimentary programming to satisfy ABPN CME and self-assessment CME activity requirements. ABPN diplomates have access to the APA's Spring Highlights meeting 2020, held virtually on April 25-26, 2020. 6. The APA is also providing CME credit and access to select articles included in ABPN's MOC Part III journal-based pilot project.
Radiology	1. ABR canceled the RISE administration scheduled for April 6, 2020, in Tucson. The next available RISE administration is scheduled for October 4, 2021, at the ABR Exam Centers in Tucson and Chicago. 2. The ABR will continue to rely on program directors, supported by their Clinical Competency Committees, to provide attestation to the completion of individual training. Details regarding rescheduling of delayed ABR Core, Qualifying and Certifying exams will be provided to the stakeholder community as soon as information is available. Additionally, we are working with the Commission on Accreditation of Medical Physics Education Programs (CAMPEP) regarding the impact on medical physics residency training. 3. The current exam schedule is as follows: • DR RISE: postponed until 2021 (Chicago and Tucson) • DR Subspecialty: postponed until 2021(Chicago and Tucson) • DR Certifying: postponed until 2021 (Chicago and Tucson) • RO Oral: postponed until 2021 (Tucson) • MP Part 3 (Oral): Postponed until 2021 (Tucson) • DR, IR/DR Core: postponed until 2021 (Chicago and Tucson)	Reduction in SA-CME requirement from 15 every three years to 10 for those completing their previous year's Online Longitudinal Assessment annual progress requirement.

	4. In response to the growing health situation posed by the coronavirus (COVID-19) pandemic, for candidates whose application to take the medical physics Part 1 Exam was set to expire on December 31, 2020, we are extending the deadline until December 31, 2021. 5. The ABR has committed to a remote exam platform starting in 2021. The decision was made after weeks of consultation with key stakeholders, including candidates, programs, associations, and societies. We are continuing those discussions as we move forward in our exam development process. 6. ABR computer-based initial certification exams will take place in a remote location of the candidate's choosing, provided that place meets a few basic requirements. Remote computer-based exams are not likely to be given at commercial testing centers (e.g., Pearson VUE) or ABR centers. The exams will use an ABR-developed exam interface similar to what has previously been used for computer-based exams. In addition, we will likely use a third-party vendor to handle exam-day security and remote monitoring. We will provide additional details about the requirements when we know more. The oral exam will use an ABR-developed platform that will combine remote proctoring with video conferencing. As with the computer-based exams, candidates will have the freedom to select a location, but it must meet a few basic requirements. The details about exam-day location and other logistics are still in development and will be communicated when we have more information. 7. The ABR Board of Governors this week determined remote exam dates for the first half of 2021. Dates for the second half of the year will be established shortly and posted on their website.	

Surgery	1. ABS family leave policies allow for an additional 2 weeks of non-clinical time beyond 4 weeks. The existing family leave policy may be applied to quarantine/COVID-19. This does not require special permission from ABS. 2. Non-voluntary offsite time that is used for clinical or educational purposes can be counted as clinical time. The types of activities done in this time should be documented by the program. 3. The ABS will accept 44 weeks of clinical time (including the non-voluntary time) for the 2019-20 academic year, without the need for pre-approval, permission, or explanation. This represents approximately a 10% decrease in time requirements. 4. For those specialties with case requirements, the ABS will accept a similar 10% decrease in total cases without the need for further documentation. 5. Program directors are entrusted, as they always are, to make a decision about the readiness of the resident for independent practice. If a resident falls below the 90% mark for cases or the 44-week mark for time in training, and the PD nevertheless endorses them as ready for independent practice, the ABS will seek a more detailed supporting statement. This might include information from the CCC, milestones achievements, entrustment through EPAs, ITE scores, evidence of leadership during this crisis, or other information. 6. Residents should assess their own progress toward the standard requirements in terms of rotations, cases, and specialty specific requirements. Residents should make a remediation proposal for gaps and share with their PDs. 7. The QE applications (and CE application for SCC) are being modified to be all online, and to allow for these variances. 8. ABS will consider on a case-by-case basis those situations in which a resident missed training for an extended period due to severe COVID-19 illness. 9. The virtual General Surgery Qualifying Exam administration failed. ABS will issue refunds. The exam will not take place in July. FAQ page can be found here http://www.absurgery.org/default.jsp?faq_virtualgsqe2020 10. The 2020 General Surgery Qualifying	ABS encourages anyone who has a grace year available to them and feels they are unable or unprepared to take this year's assessment to take their grace year.

	Exam (QE) has been rescheduled for Thursday, April 15, 2021, and will be held at Pearson VUE exam centers across the country. 11. In recognition of the negative impact of participating in the administration of the July exam, candidates who had registered for the 2020 QE will receive a $400 discount on the next exam, bringing the new price to $950. 12. ABS will extend Board Eligibility for one year for those candidates whose eligibility would expire in 2020.	
Thoracic Surgery	1. The Oral Exam that was tentatively scheduled for October 16-17, 2020, will be postponed until winter/spring of 2021. 2. Programs or candidates who anticipate a problem in achieving the ABTS case requirements for a particular pathway should contact the ABTS to request a ruling as to whether or not their case-list would be acceptable for entry into the certification process.	1. ABTS also plans to work with the doctors if they are short on CMEs since so many Annual Meetings have been postponed this spring. At this time, it will be handled on a case-by-case basis. 2. The newest edition of SESATS, XIII, is now available. SESATS is a comprehensive online tool used to study and review the essential aspects of cardiac and thoracic surgery. This latest version features 400 brand new questions with instant access to the items, in-depth critiques, real-time abstracts, and linked references. Completion of this online activity permits one to claim up to 70 AMA PRA Category 1 CME credits.
Urology	ABU will be working with the RRC to make efforts not to punish candidates who miss training due to circumstances out of their control.	1. ABU tried to offer CMEs that did not require travel to the AUA Annual Meeting. If Annual Meeting was the only option for diplomates to achieve CMEs, AUA will remain flexible about other options. 2. ABU will work with physicians to meet the deadline to submit surgical logs. It is recommended for people who are recertifying to consider waiting until 2021. 3. For those diplomates recertifying this year and unable to delay a year, log submission timeline has been extended.

**Used with permission from the ABMS. The information in this table was sourced from the ABMS on July 12, 2021, per the member board websites; some items may have expired given the fluidity of the pandemic.

APPENDIX C:
ANNOTATED BIBLIOGRAPHY

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APPENDIX D:
CURRENT HOD POLICIES RELATED TO CBC

H-275.924, "Continuing Board Certification"

AMA Principles on Continuing Board Certification
1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.
4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): Each Member board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A).
10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. CBC should be used as a tool for continuous improvement.

15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing CBC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. CBC activities and measurement should be relevant to clinical practice.
19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.
(Policy Timeline: CME Rep. 16, A-09 Reaffirmed: CME Rep. 11, A-12 Reaffirmed: CME Rep. 10, A-12 Reaffirmed in lieu of Res. 313, A-12 Reaffirmed: CME Rep. 4, A-13 Reaffirmed in lieu of Res. 919, I-13 Appended: Sub. Res. 920, I-14 Reaffirmed: CME Rep. 2, A-15 Appended: Res. 314, A-15 Modified: CME Rep. 2, I-15 Reaffirmation A-16 Reaffirmed: Res. 309, A-16 Modified: Res. 307, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 319, A-17 Reaffirmed in lieu of: Res. 322, A-17 Modified: Res. 953, I-17 Reaffirmation: A-19 Modified: CME Rep. 02, A-19)

D-275.954, "Continuing Board Certification"

Our AMA will:
1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a yearly report to the House of Delegates regarding the CBC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council s ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.

4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician s current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physician s decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.

22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board s CBC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician s practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.
36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Our AMA will, through its Council on Medical Education, continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.
38. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development of new, integrated standards for continuing certification programs by 2020 that will address the Commission's recommendations

for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.
(Policy Timeline: CME Rep. 2, I-15 Appended: Res. 911, I-15 Appended: Res. 309, A-16 Appended: CME Rep. 02, A-16 Appended: Res. 307, I-16 Appended: Res. 310, I-16 Modified: CME Rep. 02, A-17 Reaffirmed: Res. 316, A-17 Reaffirmed in lieu of: Res. 322, A-17 Appended: CME Rep. 02, A-18 Appended: Res. 320, A-18 Appended: Res. 957, I-18 Reaffirmation: A-19 Modified: CME Rep. 02, A-19, Appended: CME Rep. 1, I-20)

H-275.926, "Medical Specialty Board Certification Standards"

Our AMA:
(1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
(2) Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
(3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
(4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
(5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
(6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
(Policy Timeline: Res. 318, A-07 Reaffirmation A-11 Modified: CME Rep. 2, I-15 Modified: Res. 215, I-19)

REFERENCES

1. Report 1-N-20, Update on Maintenance of Certification and Osteopathic Continuous Certification.

2. Report 2-A-19, Update on Maintenance of Certification and Osteopathic Continuous Certification.

3. Report 2-A-18, Update on Maintenance of Certification and Osteopathic Continuous Certification.

4. Report 2-A-17, Update on Maintenance of Certification and Osteopathic Continuous Certification.

5. Report 2-A-16, Update on Maintenance of Certification and Osteopathic Continuous Certification.

6. Report 2-A-15, Update on Maintenance of Certification and Osteopathic Continuous Certification.

7. Report 6-A-14, Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure.

8. Report 4-A-13, An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure.

9. Report 10-A-12, An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure.

10. Report 11-A-12, Impact of Maintenance of Certification, Osteopathic Continuous Certification, Maintenance of Licensure on the Physician Workforce.

11. Report 3-A-10, Specialty Board Certification and Maintenance of Licensure.

12. Report 16-A-09, Maintenance of Certification/Maintenance of Licensure.

Past reports of the AMA Council on Medical Education related to CBC can be found at: https://www.ama-assn.org/councils/council-medical-education/certification-licensure-council-medical-education-reports

REPORT 03 OF THE COUNCIL ON MEDICAL EDUCATION (A-22)
Onsite and Subsidized Childcare for Medical Students, Residents and Fellows
(Resolution 304-J-21, Resolve 3)
(Reference Committee C)

EXECUTIVE SUMMARY

There is a nationwide lack of options for affordable, accessible, quality childcare for the U.S. public in general, but in particular for individuals of lower income and with work schedules that are non-traditional, varied, or inflexible. Medical students and resident physicians who are parents face childcare challenges that include low or even non-existent income, rigid academic schedules, and training and service requirements that extend the workday well beyond what can be easily accommodated by most childcare providers. Annual costs of childcare range from approximately $6,000 to $33,000, depending upon the state, age of the child, and type of provider. The U.S. Department of Health and Human Services considers childcare affordable if it costs families no more than seven percent of their income. Most working families (over 60 percent) exceed this level of expenditures for center-based childcare, regardless of parents' marital status, race, age, or education level, and across a broad range of income levels. The salaries of residents are low, particularly considering the number of hours they typically work and their job responsibilities; the median first year salary in 2021 was $58,650. Residents who are parents affirm that resources that would be most helpful to assist with childcare are onsite childcare with extended hours and childcare subsidies.

The struggle of juggling childcare and medical education can further increase stress for individuals who are in an environment shown to increase levels of depression and burnout. Affordable, onsite childcare with extended hours could address many of the concerns of all health care workers who are parents, and substantial subsidization of childcare expenses in locations where onsite childcare is impractical would provide additional and much needed support to families who face financial restrictions in obtaining affordable, flexible childcare. Meeting this need may place a significant financial burden on medical schools and graduate medical education institutions that may be operating on already small margins, but enabling families to provide a nurturing environment for young children is an essential goal for society.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-A-22

Subject: Onsite and Subsidized Childcare for Medical Students, Residents and Fellows (Resolution 304-J-21, Resolve 3)

Presented by: Niranjan V. Rao, MD, Chair

Referred to: Reference Committee C

INTRODUCTION

Resolution 304-J-21, "Decreasing Financial Burdens on Residents and Fellows," introduced by the Resident and Fellow Section (RFS), asked that the American Medical Association (AMA) work with several stakeholders to reduce some of the expenses residents and fellows experience that are a result of their training status, including assistance with managing educational debt and ensuring healthy food options in hospitals for staff and patients. Resolve 3, "That our AMA work with relevant stakeholders to ensure that medical trainees have access to on-site and subsidized child care," was referred by the House of Delegates to explore the topic further and develop recommendations to reduce financial burdens on trainees while also maintaining equity, both among trainees and among all health care workers. This report is in response to the referral.

BACKGROUND

High-quality care of young children has undisputed benefits, for the child, families, and society at large.[1] The United States, however, is an outlier in comparison to other rich nations in expectations of who provides childcare and how it is funded.

Parents in the U.S. are guaranteed (with some exceptions) 12 weeks of leave to take care of a new child without fear of losing their job—the result of the Family and Medical Leave Act (FMLA) passed in 1993—but the FMLA guarantees only unpaid leave.[2] Some states have passed laws guaranteeing some form of paid leave, and many employers provide paid leave as well.

Organizations that oversee the education, training, and eventual certification of resident/fellow physicians and medical students have specific regulations as well. In July 2021, for example, the American Board of Medical Specialties (ABMS) created policy requesting that "Member Board eligibility requirements must allow for a minimum of 6 weeks of time away from training for purposes of parental, caregiver and medical leave at least once during training, without exhausting all other allowed time away from training and without extending training. Member boards must allow all new parents, including birthing and non-birthing parents, adoptive/foster parents, and surrogates to take parental leave."[3]

Similarly, beginning in July 2022, training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) are required to provide to residents at least one paid leave of a minimum six-weeks duration for "approved medical, parental, and caregiver leave(s) of absence."[4]

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Medical schools are not required to have a parental leave policy for medical students to be accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA). In addition, although medical schools may have parental leave policy that includes medical students, a recent study found that this policy is not easily accessible for students at two-thirds of medical schools, both MD-granting and DO-granting.[5]

AVAILABILITY AND EXPENSE OF CHILDCARE IN THE UNITED STATES

While there are now established regulations regarding family leave for the U.S. population, easily accessible and affordable childcare remains elusive for the general public, although the need is great. In 2016, 40 percent of children younger than six years old were cared for solely by their parents; the remaining 60 percent—nearly 13 million children—received on average 30 hours of care per week from a non-parent. For children younger than three, non-parental care includes home-based childcare (65 percent of children—including 42 percent cared by a relative); 35 percent of children younger than three are in center-based care. Preschool-aged children are more likely to be cared for outside of the home, with 31 percent of three- to five-year-olds in home-based childcare, and 69 percent in center-based care.[1]

In 2019, 5.2 million childcare providers cared for 12.3 million children under the age of 13 in their homes.[1] Family childcare homes are typically less expensive compared to center-based childcare, often because of lower wages for family childcare providers. In 2017, the national average yearly cost of childcare for infants to four-year-olds was approximately $10,000 for center-based care and $8,000 for family home-based care.[6] In 2015, depending on the state in which the care took place, in-home-based childcare costs ranged from $25,000 to $33,000, and center-based care ranged from $5,700 to close to $16,000.[7]

Average childcare expenses for children under five in 2017 consumed 13 percent of the income of families who pay for childcare. The U.S. Department of Health and Human Services (HHS) considers childcare affordable if it costs families no more than seven percent of their income. Most working families (over 60 percent) exceed this level of expenditures for center-based childcare, regardless of parents' marital status, race, age, or education level, and across a broad range of income levels.[1]

More than half of the childcare centers serving three- to five-year-olds were open less than 30 hours per week in 2012. About half of center-based care only serves children in certain age ranges; for example, one-third of programs accept children ages three through five only. This can make it difficult for parents of younger children, or those with more than one young child, to find an acceptable childcare solution for their children. Center-based care also varies in other dimensions, including enrollment size, affiliation, and organizational structure.[1]

The lack of providers creates hard choices for families even if they can afford childcare. In a recent study, the Center for American Progress used U.S. census tracts to identify areas where there are more than three young children for every licensed childcare slot, categorizing these areas as "childcare deserts." Over half of Americans live in such deserts, with low-income and rural families more likely to live in areas that are underserved.[8]

Aside from the availability of childcare and the cost of such care, proximity to a parent's workplace, hours of operation, services for children with different abilities, cultural and language fit, and other dimensions also influence parents' childcare options. One study found that location and minimizing travel time is very important to families' decisions in that over 75 percent choose a

provider within five miles of their home, although that distance varied by whether the family lived in an urban, suburban, or rural area. Furthermore, parents were willing to pay substantially more for a provider that is one mile closer. Distance was the strongest predictor of whether a family selected a particular childcare provider, even more important than quality, cost, and other important factors for childcare decision making.[9]

Medical students and residents are at a particular disadvantage considering many of the aforementioned difficulties with finding suitable childcare. Medical students face several considerations during their preclerkship years that increase the burdens associated with childcare, including high student loan burden, schedules that often preclude income-generating work, and mandatory class attendance that affects students' ability to care for sick children (who may be excluded from childcare during illness). Once students advance to their clinical rotations, they face the added challenge of longer work hours that may begin prior to the opening of or extend past closing time of childcare facilities in addition to a general lack of control of their work schedule. Students on rotations with overnight call face additional barriers.

Residents, though salaried employees, have circumstances that make them unique in the workforce. Resident physicians have dual roles, pursuing their education while providing clinical service. Once matched into a training program by way of the National Resident Matching Program (NRMP) or other matching program, residents are obligated to matriculate into that program, with very few exceptions. Residents do not have the liberty to choose a job based upon a schedule or consider part-time or non-traditional hours to balance home responsibilities and their career. Part-time residency positions are a rarity, and the reduction in hours impacts the ability to meet educational requirements necessary for completion of training. Resident work hours are "limited" to 80 hours per week and commonly start earlier in the day and end later than typical jobs. Weekend shifts and overnight call, which can be up to a 32-hour continuous shift, further differentiate their "work hours" from others in the workforce. Part of the rigidity of residents' work schedules results from the necessary scheduling of all residents in the program to make sure the service is staffed in compliance with ACGME work hour regulations. It is imperative to contrast this with other careers, where opting for a particular schedule (e.g., part time hours, evening shifts, or weekends) may be an inconvenience or undesired, but not an impossibility. As with students, residents have little to no control over their work schedule.

REQUIREMENTS FOR CHILDCARE FOR MEDICAL STUDENTS AND RESIDENTS

There are no requirements or standards from the LCME, COCA, or ACGME regarding childcare for medical students or residents. The American Hospital Association (AHA) does not have requirements either; however, the AHA recognizes that employee stress concerning childcare is one issue that can affect employee well-being and retention and suggests that reducing these stresses may require hospitals to rethink and expand available support.[10]

CHILDCARE OPTIONS FOR MEDICAL STUDENTS AND RESIDENTS

Two articles published in the *Journal of the American Medical Association* in the 1980s promoted the need for and advantages of hospital-based childcare options. In 1989, it was reported that 40 percent of hospitals provided or helped provide some form of childcare for employees. Eleven percent had onsite childcare, and 7.3 percent had facilities located near the hospital. Larger hospitals were more likely to provide childcare benefits.[11,12] The childcare experiences of health care personnel during the COVID-19 pandemic, when many childcare providers closed, led many workers to stay home and not report to work at a time when their presence and expertise were vital.[13] In response, the leaders of the AHA, the American Nurses Association, and the AMA sent a

letter to the U.S. Congress, asking that Congress prioritize COVID-19 emergency funding, including funding for "quality child care for front line health care personnel in need through direct funding to front line health care personnel and facilities, or, like some states have done, partnering with schools and daycare centers to provide funding to ensure there is quality child care."[14] The negative effects of reduced childcare options on health care workers during the pandemic have been well documented.[15,16,17]

A 2020 survey of Association of American Medical Colleges (AAMC) member institutions found that, of the responding organizations, 49 percent provided childcare assistance before COVID-19. Of those, 62 percent (18/29) expanded childcare options during the pandemic. Of the 27 organizations (46 percent) that provided no childcare assistance before COVID-19, only two expanded their support as a result of the pandemic.[18] Early career female physicians who are parents were more likely, compared to their male counterparts, to lose childcare during the pandemic and to become the primary provider of childcare or schooling. In addition, these same mothers suffered more symptoms of depression compared to fathers during the pandemic, possibly a result of the increased work/family conflict.[19]

Before the COVID-19 pandemic, many hospitals and health care systems affiliated with graduate medical education (GME) offered forms of childcare assistance, some in the form of onsite childcare, financial subsidies, priority-status on childcare waitlists, and referral networks.[20,21,22,23] As an example, the Wellstar Health System has 11 hospitals and several clinics and facilities in Georgia, with onsite childcare centers at its two largest hospitals. The total annual budget for the two onsite centers is over $3 million. Over 240 employees typically utilize the childcare centers, including residents, fellows, and attending physicians. (Personal communication, Michele Harris, Wellstar Health System.)

Some medical schools, such as Yale School of Medicine,[24] Rush University,[25] Michigan State University,[26] University of North Texas Health Science Center,[27] and Harvard Medical School,[28] also provide childcare options and childcare subsidies for medical students. The University of Cincinnati (UC) Medical Center implemented a program at the outset of the COVID-19 pandemic through local YMCAs that allowed employees, including residents and fellows, to leave their children (six weeks and older) at a participating YMCA daycare center from 6 am to 6 pm. The medical center subsidized 50% of the daily costs for its employees. The program was discontinued, in part because the YMCA resumed its pre-COVID-19 programming. (Personal communication, Christine Ann Buczek, UC Medical Center in Cincinnati, OH.)

MEDICAL STUDENTS' AND RESIDENTS' EXPERIENCES WITH CHILDCARE

Even though most medical students and residents are in their peak childbearing years, there is relatively little known about how many will need childcare during this time and how this has changed over time. It is unknown how many students enter medical school as parents with childcare responsibilities or become parents while in medical school. The most recent Graduation Questionnaire administered by the AAMC finds that 7.3 percent of graduating seniors of MD-granting schools have a dependent who is not a partner or spouse (the type of dependent is not defined, e.g., could be a sibling, child, or parent).[29] The lack of knowledge regarding the number of students who may require childcare services prevents adequate preparation and guidance for medical schools and students.[30]

There are various estimates of the number of residents who enter GME as parents or become parents while in training. A recent six-institution survey of female residents found that 16 percent had children, and another three percent were currently pregnant.[31] In 2013, a survey of male and

female residents training at three sites of the Mayo School of Graduate Medical Education found that 41 percent of responding residents were parents (and of those, 45 percent had more than one child), and nearly 12 percent planned on having a child during their current residency.[32]

Most residents who are parents will likely have to find some form of childcare. A survey of residents in 2008 at one institution (302 respondents) found that 47 percent of parents used a childcare facility. Other options used included a stay-at-home spouse (37 percent), a nanny (25 percent), and extended family members (10 percent). A number of families relocated to take advantage of family members for childcare, after difficulties finding suitable local childcare. The monthly cost per child for facility-based childcare varied, but nearly two-thirds reported costs between $500 and $1,500 (in 2008). Most respondents with children would enroll, or strongly consider enrolling their child in hospital-based childcare, especially if extended hours or drop-in emergency childcare were available. Asked if hospital-based childcare options would influence the choice between two otherwise equal residency programs, 71 percent of all respondents—non-parents and parents—said they would rank the program with hospital-based childcare higher.[33]

A survey in 2017 of residents at six teaching hospitals (578 respondents) found that 63 percent of respondents with children had difficulty arranging childcare and relied on multiple sources for childcare. Only 10 percent reported using a daycare facility affiliated with their hospital; nonuse was typically the result of a long waitlist and inconvenience. Most residents with children desired a daycare with extended and weekend daycare hours, which were not available locally. The costs of daycare were considerable; the reported median proportion of pretax salary paid for childcare used by PGY1 and PGY2 parents was 43 percent (interquartile range 41 percent to 71 percent) and decreased modestly with increasing training.[34]

Twenty percent of 184 respondents of a 2019 survey at one GME institution had their first child during residency, and an additional 18 percent were parents when they entered residency. When asked about the experience of childcare, 60 percent of parents rated it as quite or extremely stressful, made worse when partners were working fulltime or no family members were nearby to help. Nearly 19 percent had family members relocate to help with childcare. Childcare expenses were significant; 44.3 percent of parents spent between 11 percent and 25 percent, and 37.1 percent of parents spent 26 percent or more of their family income on childcare. Childcare was used by 35.7 percent of parents, while 27.1 percent had a partner who stayed home to provide care. Parents were asked what resources would be most helpful to assist with childcare; the most preferred options were on-site day care with extended hours (51.6 percent) and childcare subsidies (25.8 percent).[35]

THE NEEDS OF THE HEALTH CARE WORKFORCE IN GENERAL

It is estimated, based on the U.S. Current Population Survey, that nearly 29 percent of the U.S. health care workforce needs to provide care for children aged 3 to 12 years.[15] Many health care workers, including residents and students, work nonstandard work hours, outside the standard business schedule of Monday through Friday, 8 am to 5 pm. The number of childcare centers that provide some form of care during nonstandard hours is small; two percent offer childcare during the evening, six percent offer overnight care, and three percent offer weekend care.[36]

Due to the relatively low salaries of most health care workers, including residents—and typically medical students are not wage earners—childcare expenses are well over the seven percent of income that HHS considers affordable. According to the Bureau of Labor Statistics, in May 2020 the median annual wage for health care practitioners and technical occupations (e.g., registered nurses, physicians, and dental hygienists) was $69,870. Health care support occupations (e.g.,

home health aides, occupational therapy assistants, and medical transcriptionists) had a median annual wage of $29,960.[37] The median salary in 2021 for first year residents was $58,650, ranging from $55,115 for first year residents training in the South, to $62,534 in the Northeast.[38]

RELEVANT AMA POLICY

D-200.974, "Supporting Childcare for Health Care Professionals"

Our AMA will work with interested stakeholders to investigate solutions for innovative childcare policies and flexible working environments for all health care professionals (in particular, medical students and physician trainees).

H-310.912, "Residents and Fellows' Bill of Rights"

(5) Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.

H-215.985, "Child Care in Hospitals"

Our AMA: (1) strongly encourages hospitals to establish and support child care facilities; (2) encourages that priority be given to children of those in training and that services be structured to take their needs into consideration; (3) supports informing the AHA, hospital medical staffs, and residency program directors of these policies; and (4) supports studying the elements of quality child care and availability of child care on a 24-hour basis.

SUMMARY AND RECOMMENDATIONS

There is a nationwide lack of options for affordable, accessible, quality childcare for the U.S. public in general, but in particular for individuals of lower income and with work schedules that are non-traditional, varied, or inflexible. Medical students and residents who are parents face childcare challenges that include low or even non-existent income, rigid academic schedules, and training and service requirements that extend the workday well beyond what can be easily accommodated by most childcare providers. The struggle of juggling childcare and medical education can further increase stress for individuals who are in an environment that has been documented to increase levels of depression and burnout.[39]

The Build Back Better Act was passed by the U.S. House of Representatives in November 2021. The bill included universal free preschool for 3- and 4-year-olds and ensured that families earning up to 1.5 times their state's median income would not pay more than seven percent of their income for childcare of young children. Also included were four weeks of federal paid parental, sick, or caregiver leave.[40] This level of assistance, if enacted, would provide medical students and residents with children some financial support, and some support in the form of childcare (preschool for 3- and 4- year-olds) but would not address the needs of parents with younger children and school-aged children as well as parents with non-traditional work schedules. Opposition in the Senate to the Build Back Better Act has led to consideration of smaller legislative action that would provide support to make childcare more affordable.

Convenience and cost are the most important factors for parents in selecting childcare arrangements. Affordable, onsite childcare with extended hours could address many of those concerns, and substantial subsidization of childcare expenses in locations where onsite childcare is impractical would provide additional, much needed support to families who face financial restrictions in obtaining affordable, flexible childcare. Enabling families to provide a nurturing environment for young children is an essential goal for society. Doing so, however, may place a significant financial burden on medical schools and graduate medical education institutions that may be operating on already small margins. If institutions are mandated to provide such services, they may attempt to recoup costs with higher tuition or lowered salaries.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 304-J-21, Resolve 3, and the remainder of this report be filed:

1. That our AMA recognize the unique childcare challenges faced by medical students, residents and fellows, which result from a combination of limited negotiating ability (given the matching process into residency), non-traditional work hours, extended or unpredictable shifts, and minimal autonomy in selecting their work schedules. (New HOD Policy)

2. That our AMA recognize the fiscal challenges faced by medical schools and graduate medical education institutions in providing onsite and/or subsidized childcare to students and employees, including residents and fellows. (New HOD Policy)

3. That our AMA encourage provision of onsite and/or subsidized childcare for medical students, residents, and fellows. (New HOD Policy)

4. That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and American Association of Colleges of Osteopathic Medicine to identify barriers to childcare for medical trainees and innovative methods and best practices for instituting on-site and/or subsidized childcare that meets the unique needs of medical students, residents, and fellows. (Directive to Take Action)

Fiscal Note: $2,500

REFERENCES

[1] U.S. Department of Treasury. *The Economics of Child Care Supply in the United States. 2021*. Accessed February 3, 2022. https://home.treasury.gov/system/files/136/The-Economics-of-Childcare-Supply-09-14-final.pdf

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-A-22

Subject: Protection of Terms Describing Physician Education and Practice (Resolution 305-J-21, Alternate Resolve 2)

Presented by: Niranjan V. Rao, MD, Chair

Referred to: Reference Committee C

INTRODUCTION

Resolution 305-J-21, "Non-Physician Postgraduate Medical Training," introduced by the American Medical Association (AMA) Resident and Fellow Section (RFS), asked that our AMA amend Policy H-275.925, "Protection of the Titles 'Doctor,' 'Resident' and 'Residency.'" Testimony on this item during the June 2021 Special Meeting led to proposed revisions to the original resolution's second resolve:

> That our AMA amend policy H-275.925 "Protection of the Titles "Doctor," "Resident" and "Residency"," by addition and deletion to read as follows:
>
> Our AMA: (1) recognizes that when used in the healthcare setting, specific terms describing various levels of allopathic and osteopathic physician training and practice (including the terms "medical student," "resident," "residency," "fellow," "fellowship," "physician," and "attending") represent the completion of structured, rigorous, medical education undertaken by physicians (as defined by the American Medical Association in H-405.951, "Definition and Use of the Term Physician"), and must be reserved for describing only physician roles; (2) will advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; and (3) supports and develops model state legislation that would penalize misrepresentation of one's role in the physician-led healthcare team, up to and including the level of ~~make it a~~ felony ~~to~~ for misrepresenting oneself as a physician (MD/DO); and (4) support and develop model state legislation that calls for statutory restrictions for non-physician postgraduate diagnostic and clinical training programs using the terms "medical student," "resident," "residency," "fellow," "fellowship," "physician," or "attending" in a healthcare setting except by physicians.

This alternate resolve was referred by the AMA House of Delegates. This report is in response to the referral.

BACKGROUND

Recognizing that there is confusion among the public as to the education, training, and skills of different health care professionals, which can lead to patients seeking and obtaining inappropriate and potentially unsafe medical care, the AMA has partnered with 105 national, state and specialty medical associations to form the Scope of Practice Partnership (SOPP). To inform SOPP's "Truth

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in Advertising Campaign," SOPP has conducted several surveys to gauge public knowledge of titles, qualifications, practices and licensure status of various health care professionals.

The first SOPP survey in 2008 found that while patients strongly support a physician-led health care team, many were confused about the level of education and training of their health care provider. Follow-up surveys conducted in 2010, 2012 and 2014 confirmed that patients were confused as to who is and who is not a physician, e.g., 80 percent believed a dermatologist was a physician, and 19 percent and 17 percent thought nurse practitioners and physician assistants, respectively, were physicians.[1] The surveys did not ask about educational or training roles, such as resident or fellow.

The AMA has addressed this issue in the past; in 2008 the Illinois Delegation introduced a resolution related to the titles "Doctor," "Resident" and "Residency." The resolution asked that the title doctor (in a medical setting) "apply only to physicians licensed to practice medicine in all its branches, dentists and podiatrists"; that the AMA "adopt policy that the title 'Resident' apply only to individuals enrolled in physician, dentist or podiatrist training programs"; that the AMA "adopt policy that the title 'Residency' apply only to physician, dentist or podiatrist training programs;" and that the AMA "serve to protect, through legislation," these titles. The action that was adopted by the HOD became Policy H-275.925, asking that all health professionals clearly identify their qualifications and training and supporting state legislation that would make it a felony to misrepresent oneself as a physician.

HEALTH CARE PROFESSIONAL TITLES AND EDUCATIONAL PROGRAMS

A brief history in medicine

It can be assumed that the general public is reasonably familiar with terms such as "medical student" and "physician," but other terms, such as resident, residency, fellow, fellowship and attending, may not be as well understood. In the health care field, the founders of Johns Hopkins Medical School in the 1890s are credited with first using the terms resident and residency to describe medical school graduates furthering their education in a clinical setting and the educational program in which that education occurs. The programs at Johns Hopkins were designed to be an intensive experience for physicians to study a specific field of medicine—so intensive, the physicians lived at the hospital.[2]

"Fellow" and "fellowship" have a long history within education, designating a senior scholar and the formal or informal organization of those scholars. Within medicine, the term fellowship as part of graduate medical education was used at least as early as the mid-1930s.[3] The term attending, when used in the hospital setting, appears to have its origins describing when private physicians would leave their clinics to "attend" to "their" patients who had been admitted to a hospital. The term has evolved to generally define a physician on the staff of a hospital with the primary responsibility over the treatment of a patient and who often supervises treatment given by interns, residents and fellows.

In other health care fields

The nursing profession has created educational modules and pilots using the term "attending," with literature describing implementation of these pilots dating back to the early 1990s.[4,5,6,7] The literature, however, does not always advocate for a "change of title or regulation" but a recognition of a stature earned.[8] Nonetheless, it is possible to find advertisements for positions called

"attending nurse,"[9] and the province of Ontario has an Attending Nurse Practitioner in Long-term Care Homes Initiative.[10]

The American Nurses Credentialing Center (ANCC) is a subsidiary of the American Nurses Association. The ANCC Practice Transition Accreditation Program® (PTAP) is recognized by the U.S. Department of Labor as a Standards Recognition Entity for Industry-Recognized Apprenticeship Programs (IRAP) and sets the global standard for residency or fellowship programs that prepare registered nurses (RNs) and advanced practice registered nurses (APRNs) to transition into new practice settings. ANCC accredits the following types of transition programs:

RN Residencies	For nurses with less than 12 months' experience
RN Fellowships	For experienced nurses to master new clinical settings
APRN Fellowships	For newly certified advanced practice nurses

There are currently 221 programs accredited by the ANCC.[11] Another organization, the National Nurse Practitioner Residency & Fellowship Training Consortium, which has just received recognition by the U.S. Department of Education, has accredited nine programs.[12] For example, Northwell Health requires all nurses with 6 months or less experience to enroll in their nurse residency and offers nursing fellowships in five clinical areas.[13] The Medical College of Wisconsin has a pediatric critical care nurse practitioner 12-month fellowship program for pediatric critical care nurse practitioners to further their training.[14]

The Association of Postgraduate PA Programs provides a list of 70 training programs, many called residency or fellowship programs,[15] while the Physician Assistant Program Directory provides a list of 85 programs.[16]

Outside of health care

As mentioned above, the terms "fellow" and "fellowship" have a long history outside of medicine. The terms "resident" and "residency" are used widely in fields outside of health care, such as in the arts,[17] engineering,[18] and journalism[19] to name only a few. Attending does not appear to be in use for modifying a position (e.g., attending physician) outside of health care.

REGULATIONS/GUIDANCE REGARDING USE OF THE TERMS IN HEALTH CARE

At this time, there appear to be no regulations by state medical boards on who can use the terms resident, residency, fellow, fellowship or attending. Medical licensure requirements reflect what someone can do under various licenses, e.g., practice medicine, but do not stipulate what an educational program is named or the titles that one can use in describing a position.

The AMA's model bill, "Health Care Professional Transparency Act," has been successfully adopted in many states and describes how health professionals should properly identify their type of license but does not include roles. Section 4.(b).1, for example, requires health care practitioners to wear a photo identification tag that includes, among other information, the person's type of license, e.g., medical doctor or nurse practitioner. The model bill does not include the roles in the health care setting that practitioners likely use when introducing themselves to patients, such as attending physician, resident, etc. Further adoption of this model legislation by additional states may help address the issue of appropriate identification of physicians (whether resident physician or fully licensed physician) versus other health professionals.

RELEVANT AMA POLICY

D-275.979, "Non-Physician 'Fellowship' Programs"

Our AMA will (1) in collaboration with state and specialty societies, develop and disseminate informational materials directed at the public, state licensing boards, policymakers at the state and national levels, and payers about the educational preparation of physicians, including the meaning of fellowship training, as compared with the preparation of other health professionals; and (2) continue to work collaboratively with the Federation to ensure that decisions made at the state and national levels on scope of practice issues are informed by accurate information and reflect the best interests of patients.

H-270.958 (2), "Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners"

Our AMA will work with interested Federation partners: (a) in pursuing legislation that requires all health care practitioners to disclose the license under which they are practicing and, therefore, prevent deceptive practices such as nonphysician healthcare practitioners presenting themselves as physicians or "doctors"; (b) on a campaign to identify and have elected or appointed to state medical boards physicians (MDs or DOs) who are committed to asserting and exercising the state medical board's full authority to regulate the practice of medicine by all persons within a state notwithstanding efforts by nonphysician practitioner state regulatory boards or other such entities that seek to unilaterally redefine their scope of practice into areas that are true medical practice.

D-35.996, "Scope of Practice Model Legislation"

Our AMA Advocacy Resource Center will continue to work with state and specialty societies to draft model legislation that deals with non-physician independent practitioners' scope of practice, reflecting the goal of ensuring that non-physician scope of practice is determined by training, experience, and demonstrated competence; and our AMA will distribute to state medical and specialty societies the model legislation as a framework to deal with questions regarding non-physician independent practitioners' scope of practice.

H-405.951, "Definition and Use of the Term Physician"

Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.

D-405.991 (1) (2), "Clarification of the Title 'Doctor' in the Hospital Environment"

1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.

2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor,"

and who is not a "physician" according to the AMA definition (H-405.969) that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

H-405.992, "'Doctor' as a Title"

The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title "Doctor," which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ.

H-405.968 (1), "Clarification of the Term 'Provider' in Advertising, Contracts and other Communications"

Our AMA supports requiring that health care entities, when using the term "provider" in contracts, advertising and other communications, specify the type of provider being referred to by using the provider's recognized title which details education, training, license status and other recognized qualifications; and supports this concept in state and federal health system reform.

SUMMARY AND RECOMMENDATIONS

There is potential confusion for the public in the use of terms describing the training program and level of training that health care professionals enroll in or complete; data are needed to assess the extent of that confusion. A standardization and understanding of terms for physicians and non-physicians will be beneficial to the public and health care professionals and could inform future proposed legislation.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 305-J-21, Alternate Resolve 2, and the remainder of this report be filed:

1. That our AMA engage with academic institutions that develop educational programs for training of non-physicians in health care careers, and their associated professional organizations, to create alternative, clarifying nomenclature in place of "resident," "residency," "fellow," "fellowship" and "attending" and other related terms to reduce confusion with the public. (Directive to Take Action)

2. That AMA Policy H-275.925, "Protection of the Titles 'Doctor,' 'Resident' and 'Residency'" be amended by insertion and deletion as follows:

   Our AMA: (1) will advocate that all health professionals in a clinical health care setting clearly and accurately ~~identify~~ communicate to patients and relevant others their qualifications, ~~and~~ degree(s) attained, and current training status within their training program; (2) ~~and~~ develop model state legislation for implementation to this effect; ~~and (2)~~ (3) supports state legislation that would make it a felony to misrepresent oneself as a physician (MD/DO)~~.~~; and (4) will expand efforts in educational campaigns that: a) address the differential education, training and licensure/certification requirements for non-physician health professionals versus physicians (MD/DO) and b) provide clarity regarding the role that physicians (MD/DO) play in providing patient care relative to other health professionals as it relates to nomenclature, qualifications, degrees attained and current training status. (Modify Current HOD Policy)

Fiscal Note: $5,000

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REPORT 5 OF THE COUNCIL ON MEDICAL EDUCATION (A-22)
Education, Training, and Credentialing of Non-Physician Health Care Providers and Their Impact on Physician Education and Training (Resolution 305-J-21, Resolve 8)
(Reference Committee C)

EXECUTIVE SUMMARY

This report is written in response to two resolves from Resolution 305-J-21, "Non-Physician Postgraduate Medical Training," which was authored by the American Medical Association (AMA) Resident and Fellow Section and submitted to the Special Meeting of the House of Delegates in June 2021. One resolve, now AMA Policy D-275.949, asked:

> That our AMA study and report back to the House of Delegates on curriculum, accreditation requirements, accrediting bodies, and supervising boards for undergraduate, graduate, and postgraduate clinical training programs for non-physicians and the impact on undergraduate and graduate medical education.

A second resolve was referred which asked:

> That our AMA oppose non-physician healthcare providers from holding a seat on the board of an organization that regulates and/or provides oversight of physician undergraduate and graduate medical education, accreditation, certification, and credentialing when these types of non-physician healthcare providers either possess or seek to possess the ability to practice without physician supervision as it represents a conflict of interest.

The accrediting bodies of undergraduate and graduate medical education address interprofessional education, collaboration, and supervision in their accreditation requirements. The differences in education and training between physicians and non-physicians, particularly nurse practitioners and physician assistants, is reviewed in greater detail in this report as well as support for and concerns regarding such interprofessional efforts.

Some boards of organizations that regulate and/or provide oversight of physicians (e.g., undergraduate and graduate medical education, accreditation, certification, and credentialing) have seats for non-physician health care providers. This may pose a conflict of interest for those non-physician health care providers who seek to practice independently of physicians. However, there can be value in having a non-physician representative on a board in order to provide additional perspective and ensure the best interests of patients.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-A-22

Subject: Education, Training, and Credentialing of Non-Physician Health Care Providers and Their Impact on Physician Education and Training (Resolution 305-J-21, Resolve 8)

Presented by: Niranjan V. Rao, MD, Chair

Referred to: Reference Committee C

INTRODUCTION

Resolution 305-J-21, "Non-Physician Postgraduate Medical Training" was authored by the American Medical Association (AMA) Resident and Fellow Section and submitted to the Special Meeting of the House of Delegates in June 2021. Its third resolved statement was adopted as amended, resulting in AMA Policy D-275.949, which asks that our AMA "study and report back to the House of Delegates on curriculum, accreditation requirements, accrediting bodies, and supervising boards for undergraduate, graduate, and postgraduate clinical training programs for non-physicians and the impact on undergraduate and graduate medical education."

In addition, the following resolve of Resolution 305-J-21 was referred:

> That our AMA oppose non-physician healthcare providers from holding a seat on the board of an organization that regulates and/or provides oversight of physician undergraduate and graduate medical education, accreditation, certification, and credentialing when these types of non-physician healthcare providers either possess or seek to possess the ability to practice without physician supervision as it represents a conflict of interest.

This report is written in response to the adopted policy and the referral. To clarify, this report is not about non-physician scope of practice, nor funding of physician vs. non-physician clinical training programs. The Council on Medical Education acknowledges the concerns articulated by the authors of these resolutions. This report seeks to investigate and discuss the issues raised in the resolutions in order to advance these learning environments.

BACKGROUND

The accrediting bodies of undergraduate and graduate medical education address interprofessional collaborations and supervision in their accreditation requirements.

Allopathic and osteopathic requirements

In evaluating non-physician educational programs and requirements, it is imperative to understand the rigors of medical training inclusive of the requirements set forth by the Liaison Committee on Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA) for undergraduate medical education as well as the Accreditation Council for Graduate Medical Education (ACGME) for graduate medical education.

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Undergraduate medical education

To achieve and maintain accreditation, a medical education program leading to the MD degree in the U.S. must demonstrate appropriate performance in the standards and elements of the LCME. According to its updated Functions and Structure of a Medical School standards released in 2021, Standard 9: Teaching, Supervision, Assessment, and Student and Patient Safety states, "A medical school ensures that its medical education program includes a comprehensive, fair, and uniform system of formative and summative medical student assessment and protects medical students' and patients' safety by ensuring that all persons who teach, supervise, and/or assess medical students are adequately prepared for those responsibilities."[1] Likewise, Standard 5: Learning Environments of the American Osteopathic Association's COCA states, "A College of Osteopathic Medicine (COM) must ensure that its educational program occurs in professional, respectful, nondiscriminatory, and intellectually stimulating academic and clinical environments. The school also promotes students' attainment of the osteopathic core competencies required of future osteopathic physicians." Further, COCA Standard 7 states, "The faculty members at a COM must be qualified through their education, training, experience, and continuing professional development and provide the leadership and support necessary to attain the institution's educational, research, and service goals. A COM must ensure that its medical education program includes a comprehensive, fair, and uniform system of formative and summative medical student assessment and protects medical students' and patients' safety by ensuring that all persons who teach, supervise, and/or assess medical students are adequately prepared for those responsibilities."[2]

Graduate medical education

The ACGME offers a single GME accreditation system that allows graduates of allopathic and osteopathic medical schools to complete their residency and/or fellowship education in ACGME-accredited programs and demonstrate achievement of common milestones and competencies. The ACGME Common Program Requirements are a basic set of standards in training and preparing resident and fellow physicians. These requirements address non-physicians' roles in resident education, both from the perspective of teaching faculty as well as the impact of non-physician learners on resident education:

- I.E. The presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education. (Core)
- I.E.1. The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and Graduate Medical Education Committee (GMEC). (Core)
- II.A.4. Program Director Responsibilities: The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care.
    - a). (3) Background and intent: The program director may establish a leadership team to assist in the accomplishment of program goals. Residency programs can be highly complex. In a complex organization, the leader typically has the ability to delegate authority to others yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.
- II.B.3.c) Any non-physician faculty members who participate in residency program education must be approved by the program director. (Core) Background and Intent: The

> provision of optimal and safe patient care requires a team approach. The education of residents by non-physician educators enables the resident to better manage patient care and provides valuable advancement of the residents' knowledge. Furthermore, other individuals contribute to the education of the resident in the basic science of the specialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the residents, the program director may designate the individual as a program faculty member or a program core faculty member.[3]

Non-physician requirements

The AMA Advocacy Resource Center (ARC) produced a Scope of Practice Data Series[4,5] to serve as a resource to state medical associations, national specialty societies, and state lawmakers on the difference in the education, training, and licensure requirements of non-physicians as compared to physicians. Two of the informational modules address nurse practitioners (NPs) and physician assistants (PAs).

The NP must hold a valid registered nurse (RN) license, have completed a graduate-level degree, and pass a state licensure examination. The educational pathways leading to a diploma and becoming a RN include an associate degree (ADN), a baccalaureate degree (BSN), or a master's degree in nursing (MSN). Moreover, some nurses who graduate with a diploma or associate degree continue to enroll in baccalaureate programs, and increasingly, some nurses with baccalaureate degrees in other fields begin their nursing education in "direct entry" master's degree programs.[6]

The Scope of Practice Data Series on the NP[5] explains in detail the journey of a physician, using a family physician as an example, through medical school, licensure exams (the United States Medical Licensing Examination, or USMLE, and Comprehensive Osteopathic Medical Licensing Examination of the United States, or COMLEX-USA), residency training, and board certification. Comparatively, it walks though the NP journey, starting with the licensure as a RN per the curriculum standards for nursing schools of the American Association of Colleges of Nursing (AACN) as well as the RN licensure exam. It explains the three types of NP programs: a masters of nursing practice (MSN), practice-focused doctor of nursing practice (DNP), or doctoral (DNP) degree program, with most NPs completing a MSN. Both MSN and DNP programs are accredited by the Commission on Collegiate Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN). The standards for NP programs, based on guidelines from the AACN ("MSN Essentials") and National Task Force on Quality Nurse Practitioner Education, Criteria for Evaluation of Nurse Practitioner Programs ("NTF Criteria"), outline the core content, skills, and knowledge a graduate of a NP program should possess. While some NP programs offer postgraduate training after attainment of the degree, similar to medical residencies, completion of a postgraduate clinical practicum is not required for licensure or certification. Further, the data series reviews NP licensure and certification and maintenance of certification. Appendix A contains an infographic from the ARC comparing the education and training of physicians and NPs.

PAs are also members of the interprofessional team under the guidance and supervision of a physician. PA education must be completed through an accredited PA program. Upon completion, students must pass the PA National Certifying Exam (PANCE) and obtain licensure in the state in which they wish to practice. Some PA schools may require completion of science courses and hands-on experience prior to admission. While accreditation standards require PA programs to provide a generalist education, the length of the program, type of degree, and specific course requirements vary by institution and state.[7]

The Scope of Practice Data Series on the PA[4] describes the same physician journey as compared to the PA. It reviews the Phase I (classroom/didactic phase) and Phase II (clinical phase) education standards of a PA set forth by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), as well as the optional postgraduate clinical practicum, licensure, certification, optional specialty certification(s), and maintenance of certification. The ARC-PA standards, which are used for the development, evaluation, and self-analysis of PA programs, maintain that PAs are "academically and clinically prepared to practice medicine on collaborative medical teams," given that "the collaborative medical team is fundamental to the PA profession and enhances the delivery of high-quality health care."[8] See Appendix B, which contains a table from the ARC comparing the education and training of physicians and PAs. The ARC can provide more information on this series as requested.

Non-physician board membership requirements

Some boards of organizations that regulate and/or provide oversight of physicians (e.g., undergraduate and graduate medical education, accreditation, certification, and credentialing) have seats for non-physician providers. Whether or not these types of non-physician providers possess or seek to possess the ability to practice without physician supervision is often not addressed in the description of the seat. Further, there is little information in the literature about boards promoting designated seats specifically to non-physician providers, other than that of a "public member" seat.

For the AMA Board of Trustees, the non-physician/public member seat is defined in its Constitution and Bylaws B-3.2.6, "Public Trustee. The public trustee shall be an individual who does not possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent, and who is not a medical student."

The Federation of State Medical Boards (FSMB) provides guidance for state medical boards on the makeup of their board seats. They recommend that at least 25 percent be public members and that such members "reside in the state and be persons of recognized ability and integrity; not be licensed physicians, providers of health care, or retired physicians or health care providers; have no past or current substantial personal or financial interests in the practice of medicine or with any organization regulated by the board (except as a patient or caregiver of a patient); and have no immediate familial relationships with any licensees or any organization regulated by the Board, unless otherwise required by law. Public members should represent a wide range of careers."[9] Often, such seats are determined by a state's governor and/or legislature. While all state medical boards are linked by the FSMB, it is not as apparent how non-physician state boards are connected to each other.

Regarding physician certification and accreditation, organizations such as the American Board of Medical Specialties (ABMS) and ACGME have not disclosed the criteria for the composition of their own boards of directors, which include non-physicians, nor is it apparent if ABMS offers recommendations on the structure and function of the boards of directors for their member boards.

DISCUSSION

Interprofessional education and collaboration: support and concerns

Interprofessional education (IPE), when students from two or more health professions learn together during all or part of their training, and collaborative practices are intended to optimize patient outcome. The AMA recognizes their value as stated in Policy D-295.934, "1. Our AMA: (A) recognizes that interprofessional education and partnerships are a priority of the American

medical education system; 2. Our AMA supports the concept that medical education should prepare students for practice in physician-led interprofessional teams. 3. Our AMA will encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners."

Accrediting bodies support interprofessional education and collaborative practice. LCME Standard 7.9 addresses interprofessional collaborative skills, stating, "The faculty of a medical school ensure that the core curriculum of the medical education program prepares medical students to function collaboratively on health care teams that include health professionals from other disciplines as they provide coordinated services to patients. These curricular experiences include practitioners and/or students from the other health professions." The ACGME's Common Program Requirement VI.E.2. states, "Teamwork: Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. (Core)"[1] Similarly, COCA Element 6.8: Interprofessional Education for Collaborative Practice (CORE) states, "In each year of the curriculum, a COM must ensure that the core curriculum prepares osteopathic medical students to function collaboratively on health care teams, adhering to the IPEC core competencies, by providing learning experiences in academic and/or clinical environments that permit interaction with students enrolled in other health professions degree programs or other health professionals."[2]

Despite the value of IPE, clinical learning environments often include learners from multiple professions and from various training programs without coordinated accountability for management of the clinical setting. Physician training can be adversely affected if the presence of multiple learners results in decreased opportunities for patient or procedural exposures.

Further, there is concern that enrolling advanced practice providers into "resident" positions can lead to reduction in the number of MD/DO graduate positions available. Differences in training and qualifications need to be carefully considered. Some medical specialty groups have spoken out about the concern of advanced practice providers in "resident" positions. The American Academy of Emergency Medicine released a statement, updated in September 2020, on Emergency Medicine Training Programs for Non-Physician Practitioners (NPP) which states that such postgraduate programs:

- Must be clear to the public by prohibiting the use of the following terms: doctor, intern, internship, resident, residency, fellow, and fellowship. The recommended term is postgraduate training program.
- Must be structured, intended, and advertised as to prepare its participants to practice only as members of a physician-led team.
- Must not interfere with the educational opportunities of emergency medicine residents and medical students. Potential detriment to resident and student education must be monitored in a comprehensive and meaningful way throughout the existence of the NPP program.
- Must be initiated with the consultation and approval of the emergency medicine residents and physician faculty.[10]

Regarding accreditation of nursing postgraduate clinical practicums, the ANCC's Practice Transition Accreditation Program® (PTAP) is recognized by the U.S. Department of Labor as a Standards Recognition Entity for Industry-Recognized Apprenticeship Programs (IRAP). It sets the global standard for postgraduate clinical practicums that prepare RNs and advanced practice RNs to transition into new practice settings. In January 2022, the National Nurse Practitioner Residency & Fellowship Training Consortium announced its federal recognition as an accrediting agency by the U.S. Department of Education. These two organizations can play a key role in fostering

interprofessional team learning environments. Should these practicums interfere with GME, the GMEC office may not have the authority necessary to make an impact, resulting in a negative consequence to the GME training program. Appropriate institutional leaders should address these concerns and foster action.

NP and PA "residents" can bill for patient care. This raises concern that systems favor these advanced practice provider practicums as a mechanism to deliver care at a reduced cost compared to staffing clinical services by resident physicians. Substituting providers with differing qualifications may harm the educational mission. Disparities in pay are also a concern as resident pay is capped due to the availability of federal support for GME funding. The same is not true for advanced practice providers in postgraduate clinical practicums, which may lead to disparity in salaries for trainees with varying entering levels of education. AMA Policy H-310.912, Resident and Fellows Bill of Rights, states, "10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels)." The use of the term "resident" to describe these postgraduate clinical practicums is another concern; this terminology is being addressed in a concurrent Council on Medical Education report, "Protection of Terms Describing Physician Education and Practice."

Interprofessional board members: support and concern

Testimony on the eighth resolve of Resolution 305 at the June 2021 Special Meeting expressed concern for non-physician health care providers holding a seat on a board with oversight of physicians, noting that this may pose a conflict of interest for those non-physician providers who seek to practice independently of physicians. On the other hand, Reference Committee C, in its report to the HOD, noted that there can be value in having a non-physician representative on a board in order to provide additional perspective and ensure the best interests of patients. Such mixed representation is already in practice on some boards (e.g., institutional review boards, hospital medical quality boards, medical specialty boards).

One example of such mixed representation is the California Medical Board, which is composed of 15 board members, 8 physician members, and 7 public members. The governor appoints 13 members, and two are appointed by the legislature.[11] A 2021 senate bill proposed adding two members from the general public to the board, giving non-physicians a slim majority; however, the author of the bill removed the proposed change before it was voted upon.[12]

In 2017, the Iowa Board of Medicine seated the first non-physician to chair the board that has overseen the licensure and regulation of the state's physicians for 130 years. At that time, only four of the nation's 70 state and territory medical boards had public members serving as chairs. Historically, Iowa governors were required to appoint members of licensing boards from lists of nominees submitted by their state trade and professional groups. However, state legislation was changed to alleviate suspicions that some licensing boards functioned more to protect members of the profession than to protect the public.[13]

Aside from the public member seat, consideration should be given to the risks as well as benefits of boards that promote seats specific to a non-physician provider as a designated seat. Some may say that non-physician health care providers can pose a conflict of interest on a board that oversees physicians, particularly for those who seek to practice independently of physicians. Others may say that not having non-physician providers on a physician oversight board may also pose a conflict, as an all-physician board may be inherently biased in its self-governance. One potential benefit of a

non-physician majority is that it could boost public confidence that the board is focused on protecting patients.

Understanding the composition of the boards that monitor non-physicians is also important. The National Council of State Boards of Nursing (NCSBN) is a not-for-profit organization whose U.S. members include the nursing regulatory bodies in the 50 states, the District of Columbia and four U.S. territories. The leadership of NCSBN consists of a board of directors and a delegate assembly. This board of directors comprises nurses as well as other professionals. The National Commission of Certification of Physician Assistants (NCCPA) is the only certifying organization for PAs in the United States. The NCCPA Board of Directors is made up of PAs as well as other professionals, and currently includes four physicians.

RELEVANT AMA POLICY

AMA policy addresses interprofessional education among health care professions students; educational preparation of physicians, including the meaning of fellowship training, as compared with the preparation of other health professionals; and the difference in education of physicians and non-physician health care workers. These and other related policies are shown in Appendix C.

Regarding non-physician seats on physician oversight boards as raised in the eighth resolve of Resolution 305 and the issue of conflict of interest (COI), the AMA does not have specific policy on COI but does have policy on COI in other situations. For example, H-235.970, "Conflict of Interest Issues and Medical Staff Leaders," states that:

> Our AMA encourages medical staffs to adopt and incorporate into their bylaws medical staff conflict of interest policies that reflect the following principles:
>
> 1. Disclosure of potential conflicts. Candidates for election or appointment to medical staff leadership positions should disclose in writing to the medical staff, prior to the date of election or appointment, any personal, professional or financial affiliations or relationships of which they are reasonably aware, including employment or contractual relationships, which could foreseeably result in a conflict of interest with their acting on behalf of the medical staff. Elected or appointed medical staff leaders should disclose potential conflicts in writing to the medical staff whenever they arise.
>
> 2. Management of conflicts. When conflicts of interest exist, elected or appointed medical staff leaders should, as appropriate, recuse themselves from the deliberative process and/or abstain from voting on the matter to which the conflict relates. The medical staff should establish a process for disqualification from the deliberative process and/or from voting on the matter at hand for any elected or appointed medical staff leader with an identified conflict who fails to disclose the interest or who fails to recuse himself or herself from the deliberative process and/or from voting on the matter to which the conflict relates, as appropriate.

Neither Council on Ethical and Judicial Affairs (CEJA) opinions nor AMA Bylaws cite an explicit definition of COI. The AMA PolicyFinder database offers more information.

SUMMARY AND RECOMMENDATIONS

The AMA believes that all qualified health care professionals play an integral role in the delivery of health care in this country—a role that should be clearly defined by one's education and training.

Reaffirmation of Policies D-295.934, "Encouragement of Interprofessional Education Among Health Care Professions Students," and D-275.979, "Non-Physician 'Fellowship' Programs," would signify this support. Such education and training of non-physicians should not inhibit in any way the education and training of physicians, thus those responsible for interprofessional education and collaborations should appropriately manage the resources for such trainings. To promote transparency, interprofessional students and trainees may benefit from training on the differences that exist among them in the amount and depth of training as well as supervision and testing of that training. Non-physician roles and seats on a board that provides oversight to physicians should be clearly defined and transparent and these boards should not take actions that inhibit in any way the education, training, or practice of physicians. Careful consideration should be given to the management of COI.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolve 8 of Resolution 305-J-21 and the remainder of this report be filed:

1. That our AMA support the concept that interprofessional education include a mechanism by which members of interdisciplinary teams learn about, with, and from each other; and that this education include learning about differences in the depth and breadth of their educational backgrounds, experiences, and knowledge and the impact these differences may have on patient care. (New HOD Policy)

2. That our AMA support a clear mechanism for medical school and appropriate institutional leaders to intervene when undergraduate and graduate medical education is being adversely impacted by undergraduate, graduate, and postgraduate clinical training programs of non-physicians. (New HOD Policy)

3. That Policies D-295.934, "Encouragement of Interprofessional Education Among Health Care Professions Students," and D-275.979, "Non-Physician "Fellowship" Programs," be reaffirmed. (Reaffirm HOD Policy)

4. That our AMA encourage medical education regulatory bodies to review their conflict of interest and other policies related to non-physician health care professionals holding formal leadership positions (e.g., board, committee) when that non-physician professional represents a field that either possesses or seeks to possess the ability to practice without physician supervision. (Directive to Take Action)

5. That Policy D-275.949, "Non-Physician Postgraduate Medical Training," be rescinded, as having been accomplished by the writing of this report.
   ~~Our AMA will study and report back to the House of Delegates on curriculum, accreditation requirements, accrediting bodies, and supervising boards for undergraduate, graduate and postgraduate clinical training programs for non-physicians and the impact on undergraduate and graduate medical education.~~ (Rescind HOD Policy)

Fiscal note: $500

APPENDIX A: Physician vs Nurse Practitioner education and training

Physicians are trained to lead

With the highest level of education and 20x the clinical training

Physicians		Nurse practitioners
4 years	Education	2–3 years
3–7 years	Residency	No residency 500–
10,000–16,000 hours	Training	720 hours

Physician education

Physician education is ...

Comprehensive: Studying all aspects of the human condition—biological, chemical, pharmacological and behavioral—in the classroom, laboratory and through direct patient care

Hands-on: Rotating through different specialties during medical school, assisting licensed physicians

Established and proven: Developing clinical judgment and medical decision-making skills through direct experience managing patients in all aspects of medicine

Physician residency is ...

Selective and specialized: Newly graduated physicians match into residency programs for 3–7 years of training in a select surgical or medical specialty

Reinforcing: Newly graduated physicians move from direct supervision to progressively increased responsibility in guided preparation for independently practicing medicine

Accredited: All residency programs are highly standardized and must be accredited by ACGME, with graded and progressive responsibility atthe core of American graduate medical education

Physician assessment and certification are ...

Thorough: Students must pass a series of exams during and following graduation from medical school, with MDs taking the USMLE and DOs taking the COMLEX

Validating: After completing an accredited residency and establishing licensed practice, physicians may obtain board certification in various specialties to further demonstrate their mastery of knowledge in a specific field of medicine

Nurse practitioner education

Nurse practitioner education is ...

Abbreviated: NPs can complete a master's (MSN) or doctorate degree (DNP), with the majority completing a master's degree in 2–3 years

Limited hands-on training: 60% of NP programs are completely or partially online

Not standardized: Unlike physician education and training there is **no** standardization for obtaining practical experience in patient care

Nurse practitioner residency is ...

Not required for graduation or licensure

Nurse practitioner assessment and certification are ...

Inconsistent: NPs must pass a national certifying exam in a specific area of focus (based on the type of program from which the NP graduated) but they are not required to practice in that area—meaning an NP certified in primary care can practice in cardiology, dermatology, neurology, orthopedics, and other specialties without any additional formal education or training

Every health care professional has an important role to play in the high-stakes field of medicine. But these high stakes demand education, experience, acumen, coordination and the robust management of care found only with physician-led teams.

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APPENDIX B: Physician education and training vs Physician Assistant[4]

	Undergraduate degree	**Entrance exam**	**Postgraduate schooling**	**Residency and duration**	**Total time for completion**	**Total patient care hours required through training**
Family Physician	Standards 4-year BA/BS	Medical College Admission Test (MCAT)	4-year doctoral program (MD or DO)	3-year family medicine residency	12-14 years	12,000-16,000 hours
Physician Assistant	Standard 4-year BA/BS (Not uniformly required)	Graduate Record Examination (GRE) (Not uniformly required)	2-2.5-year master's program (some award a bachelor's certificate or associate's)	None required	6-6.5 years	2,000 hours

APPENDIX C: Relevant AMA Policy

Interprofessional education

Encouragement of Interprofessional Education Among Health Care Professions Students D-295.934
1. Our AMA: (A) recognizes that interprofessional education and partnerships are a priority of the American medical education system; and (B) will explore the feasibility of the implementation of Liaison Committee on Medical Education and American Osteopathic Association accreditation standards requiring interprofessional training in medical schools.
2. Our AMA supports the concept that medical education should prepare students for practice in physician-led interprofessional teams.
3. Our AMA will encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners.
4. Our AMA will encourage the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to facilitate the incorporation of physician-led interprofessional education into the educational programs for medical students and residents in ways that support high quality medical education and patient care.
5. Our AMA will encourage the development of skills for interprofessional education that are applicable to and appropriate for each group of learners.

Non-Physician "Fellowship" Programs D-275.979
Our AMA will (1) in collaboration with state and specialty societies, develop and disseminate informational materials directed at the public, state licensing boards, policymakers at the state and national levels, and payers about the educational preparation of physicians, including the meaning of fellowship training, as compared with the preparation of other health professionals; and (2) continue to work collaboratively with the Federation to ensure that decisions made at the state and national levels on scope of practice issues are informed by accurate information and reflect the best interests of patients.

Physician and Nonphysician Licensure and Scope of Practice D-160.995
1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.
2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.

3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.

Practicing Medicine by Non-Physicians H-160.949
Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction, and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;
(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and
(6) opposes special licensing pathways for “assistant physicians” (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program or have not completed at least one year of accredited graduate medical education in the U.S).

The Structure and Function of Interprofessional Health Care Teams H-160.912
1. Our AMA defines 'team-based health care' as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.
2. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that she or he is trained to perform.
3. Our AMA will advocate that all members of a physician-led interprofessional health care team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.
4. Our AMA adopts the following principles to guide physician leaders of health care teams:
   a. Focus the team on patient and family-centered care.
   b. Make clear the team's mission, vision and values.
   c. Direct and/or engage in collaboration with team members on patient care.
   d. Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
   e. Foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
   f. Encourage adherence to best practice protocols that team members are expected to follow.
   g. Manage care transitions by the team so that they are efficient and effective, and transparent to the patient and family.
   h. Promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.

i. Support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group or network.
j. Facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation.
k. Review measures of 'population health' periodically when the team is responsible for the care of a defined group.

5. Our AMA encourages independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks or other networks of independent providers.
6. Our AMA will advocate that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members.

Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience.

Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.
F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.
G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.
H. Access to and protection by institutional and accreditation authorities when reporting violations.
With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11.The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.
12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

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REPORT 6 OF THE COUNCIL ON MEDICAL EDUCATION (A-22)
Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents, and Fellows
(Reference Committee C)

EXECUTIVE SUMMARY

Essential to becoming a competent physician is the ability to continually improve one's diagnostic acumen and the understanding of optimal treatment alternatives through lifelong learning. A current area of concern in medical education is whether medical school curricula and graduate medical education programs provide sufficient training in how to order complex laboratory tests and interpret the test results. Improper application of principles of clinical pathology and laboratory medicine can result in ordering incorrect or redundant lab tests and contributes to excessive costs for care.

While there is extensive inclusion of pathology in medical school curricula, the content historically has focused on anatomic pathology, with much less emphasis on clinical pathology. This pedagogy does not align with current medical practice, in which most physicians engage more in clinical pathologic applications. Many medical schools do offer elective courses in clinical pathology, but few students participate. Thus, medical schools have the appearance of teaching pathology and meeting the standards set by both the Liaison Committee on Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA), but the reality is that in most medical schools, the balance of content in the required curriculum has not been updated to align with current practice. Similarly, graduate medical education programs are recognizing the need to enhance training for residents in appropriate and cost-effective applications of laboratory medicine.

Various stakeholders have implemented initiatives to increase the knowledge of clinical pathology among medical students and residents. In 2014, The National Standards in Pathology highlighted the proposed minimum standards for all medical students to understand for practicing medicine and remaining current with medical practice. These standards evolved in 2017 into the Pathology Competencies for Medical Education (PCME), which sought to (1) create a revisable document that would be able to keep pace with current medical practice and understanding; (2) emphasize laboratory medicine; and (3) develop a shared resource of pathology competencies and educational cases highlighting the competencies for pathology faculty, educators, and students that could easily be adapted into any curriculum. The Vanderbilt School of Medicine Diagnostics and Therapeutics course and Dell Medical School Department of Diagnostic Medicine are two examples of clinical pathology integration into medical education curriculum. Additionally, innovative programs like "Choosing Wisely" can be applied in medical school and graduate medical education to bolster learning in clinical pathology and laboratory medicine.

Improving the use of clinical pathology diagnostic tools in health care will require multiple interventions across the health system, including but not limited to innovations in medical education.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-A-22

Subject: Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents, and Fellows

Presented by: Niranjan V. Rao, MD, Chair

Referred to: Reference Committee C

INTRODUCTION

American Medical Association (AMA) Policy D-295.930, "Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents, and Fellows," asks that our AMA study current practices within medical education regarding the clinical use of pathology and laboratory medicine information to identify potential gaps in training in the principles of decision-making and the utilization of quantitative evidence.

The policy stems from concern that inappropriate use and interpretation of laboratory and other diagnostic tests can lead to shortfalls in patient safety, harm to patients, and malpractice claims. The need for students and trainees to learn effective stewardship of health care resources is important as well.

This report focuses on existing and planned educational initiatives that are intended to help physicians and medical students develop knowledge and skills in the principles of decision-making and the utilization of quantitative evidence. The report: 1) summarizes current Liaison Committee on Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA) educational standards within medical education regarding pathology and laboratory medicine; 2) provides examples of integration of clinical pathology in medical education, 3) outlines relevant AMA policy; and 4) makes recommendations to the HOD.

BACKGROUND

Medical School Accreditation Standards Regarding Pathology and Laboratory Medicine

The LCME accredits medical education programs leading to the MD degree in the United States. Requirements related to pathology and laboratory medicine are addressed in LCME Standard 7: Curricular Content. This standard dictates that the faculty of a medical school ensure that the medical curriculum provides content of sufficient breadth and depth to prepare medical students for entry into any residency program and for the subsequent contemporary practice of medicine. For the purpose of this report, discussion of Standard 7 is limited solely to elements 7.2 and 7.4, which are outlined in further detail below:

> Element 7.2: Organ Systems/Life Cycle/Prevention/Symptoms/Signs/Differential Diagnosis, Treatment Planning: The faculty of a medical school ensure that the medical curriculum includes content and clinical experiences related to each organ system; each phase of the

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human life cycle; continuity of care; and preventive, acute, chronic, rehabilitative, and end-of-life care.

Element 7.4: Critical Judgment/Problem-Solving Skills: The faculty of a medical school ensure that the medical curriculum incorporates the fundamental principles of medicine, provides opportunities for medical students to acquire skills of critical judgment based on evidence and experience, and develops medical students' ability to use those principles and skills effectively in solving problems of health and disease.

In assessing compliance with Standard 7.2 and 7.4, during the site visit (typically occurring every eight years), the LCME survey team asks the school to provide the following information relevant to pathology and laboratory medicine:

Standard 7.2:
1. School and national data from the AAMC Medical School Graduation Questionnaire (AAMC GQ) on the percentage of respondents who rated preparation for clinical clerkships and electives in pathology as excellent or good.
2. Data from the Independent Student Analysis (ISA) on the percentage of respondents in each class who were satisfied with the adequacy of their education in the following content areas: education to diagnose disease; education to manage disease; education in disease prevention; and education in health maintenance.

Standard 7.4:
1. Indicate whether skills of critical judgment based on evidence and skills of medical problem-solving are taught separately as an independent required course and/or as part of a required integrated course.
2. Indicate the year(s) in which the learning objectives related to skills of critical judgment based on evidence and skills of medical problem-solving are taught and assessed.

The American Osteopathic Association's COCA accredits osteopathic medical education programs leading to the Doctor of Osteopathic Medicine (DO) degree in the United States (programmatic accreditation). Requirements related to pathology and laboratory medicine are addressed in COCA Element 6.2: Osteopathic Core Competencies, which requires colleges of medicine to "teach and educate students in order to ensure the development of the seven osteopathic core competencies of medical knowledge, patient care, communication, professionalism, practice-based learning, systems-based practice, and osteopathic principles and practice/osteopathic manipulative treatment."[1] Further, Element 6.4: Clinical Education requires institutions to define the skills to be performed by the students, the appropriate clinical setting for these experiences, and the expected levels of student responsibilities.

However, these measures of how prepared students feel for their clerkships do not fully address this issue since students are unaware of their knowledge gap, and many of their clinical role models likely do not recognize this gap in their own training as evidenced by the overutilization of laboratory tests. Additionally, critical judgment and medical problem-solving courses are heavily focused on clinical presentation without the depth of understanding about laboratory tests. Education of medical students in the United States by experts on the selection of clinical laboratory tests and interpretation of the test results remains limited. Additionally, highly complex genetic testing began to emerge in the clinical laboratory shortly after the year 2000, and changes in the medical school curriculum have been occurring at a time when the clinical laboratory tests available have dramatically increased in number, complexity, and cost. The general medical student population at large has not been effectively taught when to order such complex testing and

how to interpret the genetic test results. Medical students graduate with little to no education on how to order the correct tests, and only the correct tests, from the thousands of expensive assays available. A common estimate is that one out of every five tests performed is unnecessary.[2] Causes for inappropriate test ordering include personal, organizational, and technical factors. A physician's lack of knowledge on specific laboratory tests, potential insecurities regarding differential diagnosis, and lack of awareness about optimal ordering of tests contribute to the personal factors that impact overutilization. Lack of adequate supervision and feedback from supervisors on ordering behavior, a culture of not questioning which tests a supervisor suggests, and a lack of formal education in laboratory medicine contribute to organizational factors. Ease of laboratory testing and the inconvenient process of cancelling laboratory orders deemed unnecessary, contribute to the technical factors impacting test ordering.[3]

Concerns about Medical Student and Resident Knowledge of Pathology and Laboratory Medicine

Essential to becoming a competent physician is the understanding of the normal and pathological physiology of each organ system, the ability to apply knowledge of disease mechanisms to recognize pathophysiology, and the ability to continually improve one's diagnostic acumen and understanding of optimal treatment alternatives through lifelong learning. The teaching of pathology in medical education has traditionally been assigned to the preclinical years as a component of the basic science curriculum, with an emphasis on principles of pathogenesis and morphology. Historically, students have had little formal experience with the practice of anatomic and clinical pathology and their practical applications to patient care within the medical school curriculum.[4] As noted in a white paper on this topic from the College of American Pathologists (CAP) and the Association of Pathology Chairs (APC), "the lack of formal pathology education [is] an important deficit that could lead to inappropriate use of anatomic pathology and laboratory services by future clinicians in the care of their patients."[5]

Concerns regarding sufficient integration of pathology and laboratory medicine into and across the medical education continuum are warranted. Three of every four medical decisions derive from lab test evaluation, and the dramatic increase in the number of tests underscores the need for at least minimal training in the medical education continuum as well as a better understanding of evidence-based medicine across the continuum.[6] Additionally, research from the Centers for Disease Control and Prevention and others has found that poor knowledge and inappropriate use of laboratory tests by physicians are in part due to a lack of formal training during medical school.[1]

It is necessary to mention that other factors beyond medical education play a vital role toward improving diagnosis and reducing diagnostic error. For example, the National Academies of Sciences, Engineering, and Medicine (NASEM) outlined the following steps to achieve this goal:[7]

1. Facilitate more effective teamwork in the diagnostic process among health care professionals, patients, and their families.
2. Enhance health care professional education and training in the diagnostic process.
3. Ensure that health information technologies support patients and health care professionals in the diagnostic process.
4. Develop and deploy approaches to identify, learn from, and reduce diagnostic errors and near misses in clinical practice.
5. Establish a work system and culture that supports the diagnostic process and improvements in diagnostic performance.
6. Develop a reporting environment and medical liability system that facilitates improved diagnosis by learning from diagnostic errors and near misses.
7. Design a payment and care delivery environment that supports the diagnostic process.

8. Provide dedicated funding for research on the diagnostic process and diagnostic errors.

There has been a significant effort in medical education to integrate instruction in laboratory medicine into the curriculum; however, few students are participating in these courses. To quantify the deficits in teaching laboratory medicine, a 2014 study of LCME-accredited U.S. medical school programs found that 82 schools (84 percent) offered some course work in laboratory medicine incorporated within the existing curriculum and 76 schools (78 percent) required this course in laboratory medicine during the first two years. Coursework could include lectures, laboratory sessions, small-group learning, clinical consultations, and/or electronic/digital exercises. The median number of hours of instruction at the 76 schools was 12.5, with 8.0 hours devoted to lecture and 4.5 hours devoted to small-group problem-based learning and/or laboratory sessions. All the required coursework included a lecture component. Pathologists were involved in the teaching and played a leadership role at 81 schools (99 percent of the 82 schools with any laboratory medicine coursework).[8] The study also found that, in terms of lecture time, anatomic pathology ranged from 61 to 302 hours in the medical school curriculum, in contrast to time devoted to clinical pathology (laboratory medicine), which was about eight hours.[9] While there are many courses available in clinical pathology in medical institutions, these appear to be elective courses listed in the course directory, which are taken by very few students. This was evidenced in the same study which also found that 63% of respondents reported lack of student interest as a major barrier to optimizing laboratory medicine education. Thus, medical institutions have the appearance of teaching laboratory medicine, but the reality is that few students actually spend any time learning it.

Pathology Competencies for Undergraduate Medical Education

In 2014, the National Standards in Pathology were established by a national committee of experts, including anatomic pathology/laboratory medicine practitioners and experts in medical education, as well as members of the Undergraduate Medical Educators Sections (UMEDS) of the APC and/or the Group for Research in Pathology Education (GRIPE). The committee was organized into subcommittees to frame competencies into three major general domains and their subcategories: (1) interactions with the departments of pathology and laboratory medicine; (2) anatomic pathology, to include surgical pathology/cytopathology and end of life issues (autopsy, death certificates, and forensic considerations); and (3) laboratory medicine, to include basic principles of laboratory testing, transfusion medicine, clinical chemistry and immunology, hematology, microbiology, and molecular diagnostics.[1] The National Standards in Pathology were published on the APC website to highlight the proposed minimum standards for all medical students to understand for practicing medicine and remaining current with medical practice. These standards were extensively revised and peer reviewed.

These standards evolved in 2017 into the Pathology Competencies for Medical Education (PCME), an effort that was initiated by the Undergraduate Medical Education Committee of the APC. In addition to updating the 2014 National Standards in Pathology, PCME sought to (1) create a revisable document that would be able to keep pace with current medical practice and understanding; (2) emphasize laboratory medicine; and (3) develop a shared resource of pathology competencies and educational cases highlighting the competencies for pathology faculty, educators, and students, which are developed by or with pathologists, peer reviewed, and represent foundational understanding of pathobiology essential for clinical practice that could easily be adapted into any curriculum.[10]

In addition to these standards, the PCME developed current, peer-reviewed educational cases that highlight pathology competencies. The learning cases can be easily adapted to multiple educational modalities. The cases demonstrate the application of medical reasoning to clinical scenarios,

allowing the learner to understand and apply diagnostic principles, incorporating morphologic findings and laboratory values with discussion of the laboratory medicine essentials for accurate diagnosis and treatment.

Integrating Pathology into Clinical Education: Vanderbilt School of Medicine "Diagnosis and Therapeutics" course

Vanderbilt School of Medicine currently offers a longitudinal experience throughout the core clerkship phase via their "Diagnosis and Therapeutics" course. Course sessions align with each clinical discipline and highlight core principles of laboratory medicine and case-based review of common testing as applied in that particular field. The course prepares students by having them review high-yield information from radiology, pharmacy, and the clinical laboratories. Students build competencies in effectively using clinical laboratory testing to diagnose patients, understanding the role of radiological imaging in differential diagnosis, determining the strengths and weaknesses of the different available therapeutic options, improving selection of tests and interpretation of test results and managing situations where additional help is needed.

Accreditation Council for Graduate Medical Education Standards

The Accreditation Council for Graduate Medical Education (ACGME) sets standards for U.S. graduate medical education (GME) residency and fellowship programs and the institutions that sponsor them and renders accreditation decisions based on compliance with these standards. The ACGME recognizes that knowledge of pathology is necessary to the practice of medicine, regardless of specialty, and mandates pathology education across many of its accredited residency and fellowship programs. Common program requirements related to the principles of decision-making and the utilization of quantitative evidence are addressed in Section IV.B. ACGME Competencies, as highlighted below:

> Section IV.B.1.b). (2): Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.
>
> Section IV.B.1.c): Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care.
>
> Section IV.B.1.d): Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.
> Section IV.B.1.d). (1). (g): Residents must demonstrate competence in using information technology to optimize learning.
>
> Section IV.B.1.e). (1).(c): Residents must demonstrate competence in working effectively as a member or leader of a health care team or other professional group.
>
> Section IV.B.1.f): Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care.

ACGME Review Committees may further specify additional requirements for competencies in pathology and laboratory medicine based on the medical specialty or subspecialty.

Integrating Pathology into Graduate Medical Education: Dell Medical School Department of Diagnostic Medicine

As evidence of the growing trend of medical schools integrating pathology and laboratory medicine into the curriculum, Dell Medical School at The University of Texas at Austin (Dell Med) established a Department of Diagnostic Medicine in 2017 which includes divisions of radiology and pathology. The Department of Diagnostic Medicine integrated the traditional departments of pathology, radiology, and laboratory medicine to improve accuracy in diagnoses, make testing more convenient and efficient, lower costs, and broadly integrate patient health data with electronic health records. Dell Med earned its full accreditation by LCME and graduated its first class in 2020. The school also features a Diagnostic Radiology Residency program which earned its accreditation by the by the Accreditation Council for Graduate Medical Education in February 2021. Their inaugural residency class will begin July 2022.

Using an innovative approach to team-based care, Dell Med has activated an existing network of medical experts in the community to work collaboratively to organize diagnostic care in a way that streamlines and improves the patient experience before, during, and after testing. This unique approach also aligns with Dell Med's commitment to health informatics, broadly defined as how information technology and health data are used to improve patient care and health outcomes. To support this effort Dell Med created a Biomedical Data Science Hub in 2018. The Biomedical Data Science Hub's team of computer, information, and statistical scientists will collaborate with those at other University of Texas System entities, including the Cockrell School of Engineering, College of Natural Sciences, College of Liberal Arts, Texas Advanced Computing Center, Lyndon B. Johnson School of Public Affairs, University of Texas Health School of Public Health, and others to develop new ways to analyze complex clinical and nonclinical health-related data.

One opportunity to improve the process for educating residents on how to effectively order tests was found in the "Choose Wisely" program. To promote the effective use of health care resources, the American Board of Internal Medicine Foundation and Consumer Reports launched the "Choose Wisely" campaign in April 2012 to raise national awareness of the "Top Five" lists of tests and treatments that were overused in their specialty and did not provide meaningful benefit for patients. Following the inaugural year of the campaign, eight resident physician groups in the Department of Medicine at Vanderbilt University Medical Center were able to eliminate 1,572 redundant lab tests and help patients avoid $194,954 in medical bills.

DISCUSSION

Pathology is one of the major diagnostic disciplines with essential contributions to patient management. Magid argues that students must be educated in proper interactions with physicians/ clinical laboratory scientists in anatomic pathology and laboratory medicine to understand practical implications for patient assessment and management.[1] Nonpathology departments and GME programs often request that pathology faculty provide educational experiences to meet ACGME requirements for nonpathology trainees. Thus, pathology departments become responsible, at least in part, for the education of the majority of graduate medical trainees at a given institution.[11]

Having a national peer-reviewed repository of pathology-related competencies facilitates the use of learning objectives and educational cases in individual curricula, potentially relieving some of the load on pathology course directors to continually update curricula to keep current with the exponential expanse of knowledge, laboratory testing, and treatment options. A national repository of learning objectives and cases can be used to support pathology exposure in integrated curricula to ensure exposure to an acceptable minimum amount of pathology for all students.[6]

Inappropriate use and interpretation of laboratory and other diagnostic tests can lead to shortfalls in the quality of patient care, harm to patients, malpractice claims, and increased costs of care. Improving diagnosis in health care will require multiple interventions across the health system, including but not limited to innovations in medical education. Opportunities to improve the diagnostic process include cultivating a culture of efficient and effective intra- and interprofessional collaboration, including integration of a "diagnostic management team (DMT) model which features collaborations among pathologists, radiologists, and the treating health care professionals in order to ensure that the correct diagnostic tests are ordered and that the results are correctly interpreted and acted upon."[12] Innovative educational programs have included students and residents in DMT sessions to help learners appreciate the impact of diagnostic ordering.

As medical education prepares students and trainees on how to care for patients most effectively and efficiently, there is value in providing educational opportunities to fiscal stewardship. Physicians have an ethical obligation to be prudent stewards of the shared societal resources with which they are entrusted (*Code of Medical Ethics* 11.1.2). Programs like "Choosing Wisely" and clinical decision support systems help physicians and patients make decisions about care that are supported by evidence, not duplicative of other tests or procedures already received, free from harm, and truly necessary.

RELEVANT AMA POLICY

Among other policies that are germane to this topic, Policy H-295.995, "Recommendations for Future Directions for Medical Education," notes that "....(11) Faculties should continue to evaluate curricula periodically as a means of ensuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine. (12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care." This and other relevant AMA policies are shown in the appendix.

SUMMARY AND RECOMMENDATIONS

Accreditation entities within medical education have established competencies related to the principles of decision-making and the utilization of quantitative evidence which are available for schools to use in developing curriculum. There is a need to enhance training focus on laboratory medicine. The opportunity lies in educating and equipping students, trainees, and physicians with the effective understanding of what tests should be ordered and when the support of an expert, such as a clinical pathologist, is most beneficial. As curriculum for laboratory medicine exists but is underutilized, the AMA may be able to influence current physicians, medical students and trainees to pursue this knowledge throughout the medical education continuum.

The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That our AMA modify Policy D-155.988, "Support for the Concepts of the Choosing Wisely Program," by addition to read as follows:

   <u>(1)</u> Our AMA supports the concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program.

(2) Our AMA will promote awareness of the Choosing Wisely initiative and encourage medical schools and their teaching hospitals to incorporate concepts from the campaign into their educational offerings. (Modify Current HOD Policy)

2. That our AMA rescind Policy D-295.930, "Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows," as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal note: $5,000.

APPENDIX: RELEVANT AMA POLICY

D-295.317, “Competency Based Medical Education Across the Continuum of Education and Practice”

1. Our AMA Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.
2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation.
3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents' compensation and lifetime earnings.

H-155.998, “Voluntary Health Care Cost Containment”

(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature. (2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. (3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including house staff officers, on all aspects of hospital charges, including specific medical tests, procedures, and all ancillary services. (4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum. (5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care. (6) All physicians, practicing solo or in groups, independently or in professional association, should review their professional charges and operating overhead with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs. (7) The AMA should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care.

H-295.864, “Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians”

Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim

processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes.

H-295.921, “Federal Intervention in the Setting of Educational Standards”

The AMA strongly opposes federal intervention, through legislative restrictions, that would limit the authority of professional accrediting bodies to design and implement appropriate educational standards for the training of physicians. The AMA strongly opposes infringements and mandates on medical school curricular requirements through state and federal legislative efforts, and also recommends that state medical societies should carefully monitor such activities and notify the AMA when such intrusions take place.

H-295.995, “Recommendations for Future Directions for Medical Education”

Our AMA supports the following recommendations relating to the future directions for medical education: (1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty. (2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable. (3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals. (4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students. (5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician. (6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling. (7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication. (8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose. (9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions. (10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs. (11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine. (12) The curriculum of a medical school should be designed to provide

students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted. (13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student. (14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students. (15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged. (16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice. (17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education. (18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school. (19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines. (20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education. (21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs. (22) An essential goal of a specialty board should be to determine that

the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care. (23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public. (24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates. (25) Specialty boards should consider having members of the public participate in appropriate board activities. (26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities. (27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education. (28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued. (29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported. (30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital. (31) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems. (32) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels. (33) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education. (34) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance. (35) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance. (36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to

medical education. (37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.

H-310.929, “Principles for Graduate Medical Education”

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present. (1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty. Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program s educational objectives for the residents. (2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education. (3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school. (4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine. (5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits. (6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members. (7)

COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education. (8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the Program Requirements. The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician s education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences. (9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty. (10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty. (11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues. (12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution s GME Committee must monitor programs supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient s attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident s participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times. (13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board

certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS. (14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty. (15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician s specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

H-310.960, “Resident Education in Laboratory Utilization”

Our AMA endorses the concept of practicing physicians devoting time with medical students and resident physicians for chart reviews focusing on appropriate test ordering in patient care.

H-310.968, “Opposition to Centralized Postgraduate Medical Education”

Our AMA (1) continues to support a pluralistic system of postgraduate medical education for house officer training; and (2) opposes the mandatory centralization of postgraduate medical training under the auspices of the nation's medical schools.

H-480.944, “Improving Genetic Testing and Counseling Services”
Our AMA supports: (1) appropriate utilization of genetic testing, pre- and post-test counseling for patients undergoing genetic testing, and physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) the development and dissemination of guidelines for best practice standards concerning pre- and post-test genetic counseling; and (3) research and open discourse concerning issues in medical genetics, including genetic specialist workforce levels, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic testing and counseling on patient care and outcomes.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(A-22)

Introduced by: New York

Subject: Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic

Referred to: Reference Committee C

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1 Whereas, There is a physician shortage facing our nation; and[i]
2
3 Whereas, The shortage is going to worsen since 2 of 5 current physicians will be 65 years or
4 older and in retirement age this year; and[i]
5
6 Whereas, The shortage is amplified now during the COVID-19 pandemic, demonstrating now
7 more than ever the need for a sufficient and robust physician workforce; and[i]
8
9 Whereas, An unprecedented number of physicians now plan to retire in the next year and many
10 of whom are under 45 years old and therefore would be retiring earlier than expected by
11 workforce shortage predictors due to COVID-19; and[ii]
12
13 Whereas, 8% of physicians surveyed across the United States have closed their practices
14 during the pandemic, amounting to approximately 16,000 closed practices further exacerbating
15 the shortage of healthcare providers; and[iii]
16
17 Whereas, The COVID-19 pandemic has placed immense financial strain on physicians across
18 specialties who have reported loss of staff, lack of reimbursement, and closure of independent
19 physician practices during the COVID-19 pandemic; and[iii,iv]
20
21 Whereas, Young physicians are expected to be part of the workforce for many years to come,
22 yet the majority of healthcare workers (HCW) who died during the COVID-19 pandemic were
23 under 60 years old with primary care physicians (PCPs) accounting for a disproportionate
24 number of these HCW deaths; and[v,vi]
25
26 Whereas, Before the pandemic, the physician shortage in New York State (NYS) was already
27 predicted to be between 2,500 and 17,000 by 2030; and[vii]
28
29 Whereas, During the pandemic, the shortage has been amplified in that New York City has had
30 the highest COVID-19 death rate in the country with NYS accounting for the greatest number of
31 HCW deaths in the USA; and[v,viii]
32
33 Whereas, 73% of medical students graduated with debt in 2020; and[ix]
34
35 Whereas, The cost of medical school has increased 129% in the past 20 years after adjusting
36 for inflation, affecting newer generations of students and physicians substantially more than past
37 ones; and[x]

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

Whereas, In the United States, 50% of low-income medical school graduates have educational debt that exceeds $100,000; and[x]

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

Whereas, A recent study found that higher debt levels among medical students is more likely to motivate them to choose higher paying specialties than primary care specialties; and[xii]

Whereas, Higher burdens of educational debt has been demonstrated to cause residents to place greater emphasis on financial considerations when choosing a specialty; and[xiii]

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

Whereas, It is well-established that health inequities existed before the pandemic in that individuals with low socioeconomic status are more likely to also be from minority populations, and are more likely to have worse health outcomes; and[xvi]

Whereas, These inequities have now been exacerbated by the pandemic, with the heaviest burden of COVID-19 disease falling upon Black, Latinx, and immigrant communities; and[xvii]

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

Whereas, 72% of physicians surveyed across specialties reported loss of income during the pandemic, with over half of these respondents reporting losses of 26% or more; and[iii]

Whereas, Policies modeled to include provisions for debt relief or increase in incomes were found by one study to be more likely to incentivize students to choose primary care physician specialties; and[xix]

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

Whereas, $50 billion of the initial CARES Act Provider Relief Fund were allocated to support the current healthcare system by giving hospitals and providers funding “to support health care-related expenses or lost revenue attributable to COVID-19...”; however, funding formulas based on market shares of Medicare costs and total patient revenue are most likely to bankrupt independent physicians, specifically primary care providers; and[xx,xxi]

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

significantly less net present value than primary care internists who received military or private funding; and[xxii]

Whereas, Medical education debt has been shown to be a significant barrier for underrepresented minorities and low/middle income strata students to choose medicine for a career; and[xxii]

Whereas, A key strategy to address health needs of underserved communities involves recruiting students from these communities as they may be more likely to return to address local health needs; and[xxiii]

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

Whereas, There is currently a student debt forgiveness resolution in the United States Senate to cancel $50,000 of student debt which will also apply to all medical students, training physicians, and early career physicians; and[xxv]

Whereas, Data suggests women and people of color will benefit most from such debt cancellation because they are most in need; therefore be it[xxv]

RESOLVED, That our American Medical Association study the issue of medical education debt cancellation and consider the opportunities for integration of this into a broader solution addressing debt for all medical students, physicians in training, and early career physicians. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

RELEVANT AMA POLICY

Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953
In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt.
Citation: Res. 202, I-20

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit:

(a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(A-22)

Introduced by: Resident and Fellow Section

Subject: Resident and Fellow Access to Fertility Preservation

Referred to: Reference Committee C

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1 Whereas, The average age at completion of medical training in the United States is
2 approximately 31.6 years overall[1] and 36.8 years for surgical trainees[2]; and
3
4 Whereas, Female fertility is known to decrease substantially after age 35,[3,4] with a nearly 50%
5 drop from the early 20s to late 30s[5]; and
6
7 Whereas, Female physicians have a chance of infertility that is twice that of the general
8 population (24.1% vs. 10.9%), with an average age at diagnosis of 33.7 years[1]; and
9
10 Whereas, The demands of residency increase the risk of pregnancy complications, with a higher
11 rate of gestational hypertension, placental abruption, preterm labor, and intrauterine growth
12 restriction among female residents[6–8]; and
13
14 Whereas, A majority of recent trainees perceive a stigma associated with pregnancy during
15 training[9] and have concerns about workplace support,[10] which may deter medical students from
16 choosing a career in a surgical or other field with longer and demanding training; and
17
18 Whereas, Approximately one third of program directors have reported discouraging pregnancy
19 among residents in surgical training programs[10]; and
20
21 Whereas, Oocyte cryopreservation is an established method of preserving fertility[11] that can
22 cost $10,000 per cycle, often with multiple cycles required, and $500 per year for storage,[12] in
23 addition to requiring timely injection of ovarian stimulation medications and numerous outpatient
24 visits for cycle monitoring and egg retrieval[13]; and
25
26 Whereas, Companies such as Google, Apple, and Facebook have been offering oocyte
27 cryopreservation benefits to their workforce, who are similarly largely of reproductive age, for
28 several years[14]; therefore be it
29
30 RESOLVED, That our American Medical Association support education for residents and
31 fellows regarding the natural course of female fertility in relation to the timing of medical
32 education, and the option of fertility preservation and infertility treatment (New HOD Policy); and
33 be it further
34
35 RESOLVED, That our AMA advocate inclusion of insurance coverage for fertility preservation
36 and infertility treatment within health insurance benefits for residents and fellows offered through
37 graduate medical education programs (Directive to Take Action); and be it further

1 RESOLVED, That our AMA support the accommodation of residents and fellows who elect to
2 pursue fertility preservation and infertility treatment, including the need to attend medical visits
3 to complete the oocyte preservation process and to administer medications in a time-sensitive
4 fashion. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/04/22

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RELEVANT AMA POLICY

Disclosure of Risk to Fertility with Gonadotoxic Treatment H-425.967

Our AMA: (1) supports as best practice the disclosure to cancer and other patients of risks to fertility when gonadotoxic treatment is used; and (2) supports ongoing education for providers who counsel patients who may benefit from fertility preservation.
Citation: Res. 512, A-19

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.
Citation: Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14

Infertility Benefits for Veterans H-510.984

1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.

2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries. Citation: CMS Rep. 01, I-16Appended: Res. 513, A-19

Right for Gamete Preservation Therapies H-65.956
1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies. Citation: Res. 005, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(A-22)

Introduced by: Women Physicians Section

Subject: Fatigue Mitigation Respite for Faculty and Residents

Referred to: Reference Committee C

Whereas, During the COVID-19 pandemic, physicians have been on the front lines, and have experienced increased duress and extreme fatigue during the case surges as hospitals are overrun with patients; and

Whereas, Longer shifts, disruptions to sleep and to work-life balance, and occupational hazards associated with exposure to COVID-19 have contributed to physical and mental fatigue; and

Whereas, About 20-30 percent of shift workers experience prominent insomnia symptoms and excessive daytime sleepiness consistent with circadian rhythm sleep disorder, also known as shift work disorder;[5] and

Whereas, Drowsy driving causes almost 1,000 estimated fatal motor vehicle crashes in the United States (2.5 percent of all fatal crashes), 37,000 injury crashes, and 45,000 property damage-only crashes;[2] and

Whereas, Physicians have a higher likelihood of dying from accidents than from other causes relative to the general populations;[4] and

Whereas, Physicians' risk of crashing while driving after working extended shifts (≥24 hours) was 2.3 times greater and the risk for a "near miss" crash was 5.9 times greater, compared to a non-extended shift. The estimated risk of a crash rose by 9.1 percent for every additional extended work shift hour;[3] and

Whereas, Forty-one percent (41%) of physicians report falling asleep at the wheel after a night shift;[6] and

Whereas, A simulation study demonstrated that being awake for 18 hours, which is common for physicians working a swing shift (i.e., from 6 p.m. to 2 a.m.), produced an impairment equal to a blood alcohol concentration (BAC) of 0.05 and rose to equal 0.10 after 24 hours without sleep;[7] and

Whereas, Driving simulator studies show driving home from the night shift is associated with two to eight times the incidents of off track veering, decreased time to first accident, increased eye closure duration, and increased subjective sleepiness. Night-shift work increases driver drowsiness, degrading driving performance and increasing the risk of near-crash drive events;[8] and

Whereas, Actual driving studies post-night shift versus post-sleep night showed eleven near-crashes occurred in 6 of 16 post night-shift drives (37.5 percent), and 7 of 16 post night-shift drives (43.8 percent) were terminated early for safety reasons, compared with zero near-crashes or early drive terminations during 16 post-sleep drives;[9] and

Whereas, AMA Policy H-15.958, "Fatigue, Sleep Disorders, and Motor Vehicle Crashes," notes the risks associated with sleep deprivation and actions physicians can take to help protect patients; therefore be it

RESOLVED, That our American Medical Association make available resources to institutions and physicians that support self-care and fatigue mitigation, help protect physician health and well-being, and model appropriate health promoting behaviors (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for policies that support fatigue mitigation programs, which include, but are not limited to, quiet places to rest and funding for alternative transport including return to work for vehicle recovery at a later time for all medical staff who feel unsafe driving due to fatigue after working. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 03/31/22

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RELEVANT AMA POLICY

Resident/Fellow Clinical and Educational Work Hours H-310.907
Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:
1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as "duty hours").
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-

specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: “Total clinical and educational work hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time.
c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”
f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
i) Scheduled time providing patient care services of limited or no educational value should be minimized.
j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.
l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.

m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.
o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.
8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.
9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.
Citation: CME Rep. 5, A-14; Modified: CME Rep. 06, I-18

Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958
Our AMA: (1) recognizes sleepiness behind the wheel as a major public health issue and continues to encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups
(2) recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions.
(3) recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep.
(4) encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness- testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment.
(5) urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology.
(6) recommends that physicians: (a) become knowledgeable about the diagnosis and management of sleep-related disorders; (b) investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories; (c) inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries; (d) advise patients about possible medication-related effects that may impair their ability to safely operate a moto vehicle or other machinery; (e) inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries; and (f) become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice.
(7) encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state.
(8) recommends that states adopt regulations for the licensing of commercial and private drivers with sleep-related and other medical disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries.
(9) reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.
Citation: CSA Rep. 1, A-96; Appended: Res. 418, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(A-22)

Introduced by: Resident and Fellow Section

Subject: Organizational Accountability to Resident and Fellow Trainees

Referred to: Reference Committee C

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1 Whereas, The stated mission of the Accreditation Council for Graduate Medical Education
2 (ACGME) is to, "improve healthcare and population health by assessing and advancing the
3 quality of resident physicians' education through accreditation"[1]; and
4
5 Whereas, To achieve its mission the ACGME has determined that it has two main purposes:
6 "(1) to establish and maintain accreditation standards that promote the educational quality of
7 residency and subspecialty training programs; and (2) to promote conduct of the residency
8 educational mission with sensitivity to the safety of care rendered to patients and in a humane
9 environment that fosters the welfare, learning, and professionalism of residents,"[1]; and
10
11 Whereas, While the ACGME has taken steps to advocate for residents, its ability to effectively
12 and timely work on their behalf is limited by "blunt tools" related to removal of accreditation and
13 delay in providing feedback to programs[3]; and
14
15 Whereas, Our AMA Residents and Fellows' Bill of Rights (H-310.912) establishes that residents
16 and fellows have rights to: (1) have a safe workspace that enables them to fulfill their clinical
17 duties and educational obligations; (2) defend themselves against any allegations presented by
18 a patient, health professional, or training program in accordance with due process guidelines
19 established by the AMA; (3) be able to file a formal complaint with the ACGME to address
20 program violations of residency training requirements without fear of recrimination and with the
21 guarantee of due process; and (4) confidentially evaluate faculty and programs and expect that
22 the training program will address deficiencies by these evaluations in a timely fashion[4]; and
23
24 Whereas, Resident and fellow trainees still endure suboptimal training conditions, with recourse
25 to address these issues limited by multiple factors including a high debt burden and fear of their
26 program losing accreditation thus affecting future career prospects, which ultimately makes
27 reporting even gross ACGME guideline infractions difficult to encourage[5,6]; and
28
29 Whereas, During the COVID-19 pandemic, residents and fellow trainees have been particularly
30 susceptible to poor conditions including limited availability of personal protective equipment
31 (PPE), longer work hours, lack of hazard pay or similar programs, redeployment into other
32 specialties which may or may not be relevant to education in their own specialty, and difficulty in
33 securing workers' compensation in the event of severe illness, with many programs revoking
34 promised stipend increases[6]; and
35
36 Whereas, The rate of closure of family medicine residency programs is increasing, and the
37 Federation of State Medical Boards (FSMB) has records of over 50 hospitals with accredited
38 training programs that have closed, with indications that more closures can be expected across
39 the country in multiple specialties[7,8]; and

Whereas, As exemplified by the Hahnemann University Hospital closure, residents and fellow trainees are vulnerable to the negative effects of hospital closures that threaten the quality and completion of their graduate medical education, financial wellbeing, and legal status within the United States,[9,10]; and

Whereas, Numerous organizations such as the ACGME, AMA, American Osteopathic Association (AOA), American Board of Medical Specialties (ABMS), Association of American Medical Colleges (AAMC), Council of Medical Specialty Societies, National Board of Medical Examiners (NBME), Pennsylvania Medical Society (PAMED), Philadelphia County Medical Society (PCMS), and Educational Commission for Foreign Medical Graduates (ECFMG) responded to the Hahnemann closure as well as other residency closures with offers of legal assistance, grants, visa assistance, tail-insurance coverage, and other forms of support[11]; and

Whereas, The majority of funding for Graduate Medical Education (GME) is through Medicare and Medicaid, with additional funding through the U.S. Department of Veteran Affairs (VA) and Health Resources and Services Administration (HRSA), as well as private hospital funding[12]; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) is tasked with distributing the majority of GME funding, but is not responsible for overseeing the quality of training programs nor the wellness or treatment of trainees[12]; and

Whereas, None of the organizations that responded to the Hahnemann residency closures were required to by law, nor was the response coordinated, regulated, or monitored by any type of oversight organization with regards to resident and fellow interests, and an ACGME investigation of the closure of the Hahnemann University Hospital found that no existing organizations represented resident and fellow interests to the exclusion of other stakeholder interests.[3,11]; therefore be it

RESOLVED, That our American Medical Association work with relevant stakeholders to: (1) determine which organizations or governmental entities are best suited for being permanently responsible for resident and fellow interests without conflicts of interests; (2) determine how organizations can be held accountable for fulfilling their duties to protect the rights and wellbeing of resident and fellow trainees as detailed in the Residents and Fellows' Bill of Rights; (3) determine methods of advocating for residents and fellows that are timely and effective without jeopardizing trainees' current and future employability; (4) study and report back by the 2023 Annual Meeting on how such an organization may be created, in the event that no organizations or entities are identified that meet the above criteria; and (5) determine transparent methods to communicate available residency positions to displaced residents. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/04/22

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RELEVANT AMA POLICY

Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits

including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient

care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.

10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11.The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.
12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.
Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(A-22)

Introduced by: Resident and Fellow Section

Subject: Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc., Equitable for IMGS

Referred to: Reference Committee C

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1 Whereas, United States Medical Licensing Examination (USMLE) fees are steep as a US
2 medical student: Step 1 $645, Step 2 $6451,2; and
3
4 Whereas, USMLE fees are even higher for International Medical Graduates (IMGs): Step 1
5 $975, Step 2 $975[3]; and
6
7 Whereas, If a medical student takes the USMLE Step 1 or 2 exams outside the US, there is an
8 additional delivery fee of the electronic test of $180 for Step 1 and $200 for Step 2[4]; and
9
10 Whereas, In 2020, over 52,000 US MD/DO and IMG applicants applied to residencies (over
11 $38M for US MD/DO med students and over $40M for IMGs in USMLE Step 1 and 2 fees)[5]; and
12
13 Whereas, In 2018, 21,393 graduates applied for Educational Commission for Foreign Medical
14 Graduates (ECFMG) certification and only 9,431 were certified[6]; and
15
16 Whereas, ECFMG certification ($60 in 2013; $150 in 2021) is required to take USMLE Step 3
17 for IMGs: primary source of verification of credentials ($60) + passing USMLE exams[3,7]; and
18
19 Whereas, In 2019, IMGs constituted 22% of physicians in training in residency, yet their costs to
20 apply to become physicians in the US is much greater than their US counterparts[8]; and
21
22 Whereas, During the COVID-19 pandemic and suspension of USMLE Step 2 CS, ECFMG
23 required IMGs to pass an Occupational English Test (OET) ($444) (online courses available for
24 purchase from official OET sites), if students fit within 5 defined pathways ($900)[9,10]; and
25
26 Whereas, Prior to the cancellation of the USMLE Step 2 CS exam, examination fees rose year
27 after year, but even more so for IMGs (~ $1600 in 2020, up from ~$1420 in 2013) compared to
28 US counterparts (~ $1280 in 2020, up from ~$1200 in 2013)[11]; and
29
30 Whereas, ECFMG also provides an alternative way to verify credentials through Electronic
31 Portfolio of International Credentials (EPIC) that costs $130 ($125 in 2020) and $100 ($90 in
32 2020) to confirm each credential and costs $50 to deliver each subsequent EPIC report[12]; and
33
34 Whereas, The ECFMG net assets in 2018 were $151,818,498[13]; therefore be it
35
36 RESOLVED, That our American Medical Association work with all relevant stakeholders to
37 reduce application, exam, licensing fees and related financial burdens for international medical
38 graduates (IMGs) to ensure cost equity with US MD and DO trainees (Directive to Take Action);
39 and be it further

RESOLVED, That our AMA amend current policy H-255.966, "Abolish Discrimination in Licensure of IMGs," by addition to read as follows:

2. Our AMA will continue to work with the FSMB to encourage parity in licensure requirements, and associated costs, for all physicians, whether U.S. medical school graduates or international medical graduates. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/04/22

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RELEVANT AMA POLICY

Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association D-275.950
Our AMA: (1) will take immediate, expedited action to encourage the National Board of Medical Examiners (NBME), Federation of State Medical Boards (FSMB), and National Board of Osteopathic Medical Examiners (NBOME) to eliminate centralized clinical skills examinations used as a part of state licensure, including the USMLE Step 2 Clinical Skills Exam and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2 - Performance Evaluation Exam; (2) in collaboration with the Educational Commission for Foreign Medical Graduates (ECFMG), will advocate for an equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills competency; (3) strongly encourages all state delegations in the AMA House of Delegates and other interested member organizations of the AMA to engage their respective state medical licensing boards, the Federation of State Medical Boards, their medical schools and other interested credentialling bodies to encourage the elimination of these centralized, costly and low-value exams; and (4) will advocate that any replacement examination mechanisms be instituted immediately in lieu of resuming existing USMLE Step 2-CS and COMLEX Level 2-PE examinations when the COVID-19 restrictions subside.
Citation: Res. 306, I-20

AMA Principles on International Medical Graduates H-255.988
Our AMA supports:
1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.

6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.

22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
Citation: BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03; Reaffirmation I-11; Reaffirmed: CME Rep. 1, I-13; Modified: BOT Rep. 25, A-15; Modified: CME Rep. 01, A-16; Appended: Res. 304, A-17; Modified: CME Rep. 01, I-17; Reaffirmation: A-19; Modified: CME Rep. 2, A-21

Abolish Discrimination in Licensure of IMGs H-255.966
1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):
A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.
C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.
E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards (FSMB) and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.
2. Our AMA will continue to work with the FSMB to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.
3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.
4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.
5. Our AMA will: (a) encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas; and (b) encourage the FSMB and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure--including successes, failures, and barriers to implementation.
Citation: BOT Rep. 25, A-15; Appended: CME Rep. 4, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(A-22)

Introduced by: Illinois, American Society of Anesthesiologists

Subject: Creating a More Accurate Accounting of Medical Education Financial Costs

Referred to: Reference Committee C

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1 Whereas, The usual reference to the cost of medical education typically is the summation of
2 tuition for the period of 4 years of medical education; and
3
4 Whereas, There are 3 years of required postgraduate training prior to a medical school
5 graduate's ability to fully practice medicine, during which time school loans are typically deferred
6 and interest is compounded; and
7
8 Whereas, Matriculation into medical school typically requires completion of a four-year
9 undergraduate degree; and
10
11 Whereas, The demands of medical education typically prohibit students from undertaking
12 simultaneous endeavors that provide remuneration for their work; and
13
14 Whereas, Most postgraduate medical education is performed in large urban settings where
15 cost-of-living consumes much of the stipend paid to interns and residents leaving little for
16 repayment of school loans; and
17
18 Whereas, The frequently publicized cost of medical education underrepresents the actual
19 financial responsibility of the prospective medical student and the general public; therefore be it
20
21 RESOLVED, That our American Medical Association study the costs of medical education,
22 taking into account medical student tuition and accrued loan interest, to come up with a more
23 accurate description of medical education financial costs. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/07/22

RELEVANT AMA POLICY

D-305.984 - Reduction in Student Loan Interest Rates
…
3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.
4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.

5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training.

Res. 316, A-03 Reaffirmed: BOT Rep. 28, A-13 Appended: Res. 302, A-13 Modified and Appended: 301, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(A-22)

Introduced by: Illinois

Subject: Parental Leave and Planning Resources for Medical Students

Referred to: Reference Committee C

Whereas, The number of women enrolled as first year medical students has recently risen to the majority of 51.6% in 2018[1]; and

Whereas, The average age of matriculated first year medical students is 24[2]; the average amount of time specialized physicians spend in post high school training is 14 years[3], and the average age of mothers at first birth in the United States is 26.8 years[4]; and

Whereas, 9.2% of medical students are parents by graduation[5], and thus it is essential to address the potential of pregnancy and parenthood during the course of medical education; and

Whereas, The rate of attrition for premedical females who ultimately attend medical school is significantly higher than expected due to social factors including policies regarding parental leave, which influence students to opt for a more accommodative career[6]; and

Whereas, The perceived higher compatibility of maintaining a family life with a career as a physician assistant rather than a physician has led to an increase in female physician assistant students at a rate higher than the rate of increase of female medical students[7]; and

Whereas, A survey of students from the South Dakota Sanford School of Medicine shows that medical students of all genders largely want schools to provide “clear, well-defined guidelines, scheduling flexibility and administrators who are approachable and understanding of their individual circumstances” regarding pregnancy and parenthood[5]; and

Whereas, Amongst the barriers that have been identified by female faculty physicians that prevent the advancement of qualified women in academic medicine are workplace policies that do not allow for women to maintain a balanced lifestyle in fear of not advancing in their careers[8]; and

Whereas, A survey across 11 academic medical institutions of residents in internal medicine, family practice, pediatrics, medicine–pediatrics, surgery, and obstetrics–gynecology, found that women residents were more likely than their male counterparts to intentionally postpone pregnancy because of perceived threats to their careers[9]; and

Whereas, Though there is limited research on medical student family planning, research focusing on residents and physicians, summarized above, suggests that early-career professionals of all genders express a desire for well-defined guidelines and policies promoting work-life harmony without effects on career opportunities. It is reasonable to assume that the opinions of residents, in conjunction with the data from South Dakota Sanford School of Medicine, can be extrapolated to medical students; and

Whereas, The Family and Medical Leave Act (FMLA) requires qualifying employers to give up to 12 weeks of unpaid leave to bond with a newborn or newly adopted child and the ability to apply other paid leave time towards FMLA-protected parental leave[10]; and

Whereas, The FMLA does not have protections for students, and thus schools are not required by law to accommodate parental leave[10]; and

Whereas, Current AMA, LCME and COCA policy does not require medical schools to help medical students in family planning or lay out clear policy addressing how assignments and/or classes can be made up in a way that would be amenable to family planning, and thus many schools do not provide resources outside of individual consultation; and

Whereas, The average proportion of medical students who are parents nearly triples between matriculation (3.0%)[11] and graduation (8.9%)[12]; and

Whereas, Medical students from every medical school have anecdotally expressed difficulties regarding family planning in medical school; and

Whereas, A majority of female physicians surveyed have regrets about family planning decisions and career decision-making, and if given the chance would have made decisions such as attempting conception earlier (28.6%), choosing a different specialty (17.1%), or using cryopreservation to extend fertility (7%)[13]; and

Whereas, 68.2% of medical students whose first pregnancy was in medical school and 88.6% of those whose first pregnancies occurred in training perceived substantial workplace support, indicating a lack of policy and support at medical schools comparative to residency training programs[14]; and

Whereas, It is unrealistic and inappropriate to expect trainees to delay childbearing or to forgo spending critical time with their infants, indicating the necessity of alternative solutions to improve family leave in undergraduate medical education; and

Whereas, There is little to no literature on medical students who are fathers, but they should also be allowed to spend critical time with their newborns; and

Whereas, A study addressing, “the common personal and professional challenges that medical students who are also parents face during their undergraduate medical education” found that by addressing the following: lack of career advisory and support networks for parents/expecting parents, unaccommodating schedules requiring formal leaves of absence, and childcare facilitated by the institution and challenges of breastfeeding support, medical schools can support the health and promote the education of their students[15]; and

Whereas, Students who take leaves for family planning may be negatively impacted during their training and the residency application process due to the opinions of faculty evaluators regarding leave, and residency programs’ negative perception of gaps in medical training[16]; and

Whereas, There are clear burdens and stress on medical students, particularly female medical students, and medical school administrators do not counsel and provide trainees with clear information about the impact of childbearing and family leave on coursework; and

Whereas, Medical educators should have established resources and policies that are as accommodating as possible; and

Whereas, Requesting information is often a barrier to access of knowledge, and this information is not freely and publicly available to students; therefore be it

RESOLVED, That our American Medical Association encourage medical schools to create comprehensive informative resources that promote a culture that is supportive of their students who are parents, including information and policies on parental leave and relevant make up work, options to preserve fertility, breastfeeding, accommodations during pregnancy, and resources for childcare that span the institution and the surrounding area (New HOD Policy); and be it further

RESOLVED, That our AMA encourage medical schools to give students a minimum of 6 weeks of parental leave without academic or disciplinary penalties that would delay anticipated graduation based on time of matriculation (New HOD Policy); and be it further

RESOLVED, That our AMA encourage that medical schools formulate, and make readily available, plans for each year of schooling such that parental leave may be flexibly incorporated into the curriculum (New HOD Policy); and be it further

RESOLVED, That our AMA urge medical schools to adopt policy that will prevent parties involved in medical training (including but not limited to residency programs, administration, fellowships, away rotations, physician evaluators, and research opportunities) from discriminating against students who take family/parental leave (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for medical schools to make resources and policies regarding family leave and parenthood transparent and openly accessible to prospective and current students. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 04/07/22

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RELEVANT AMA POLICY

Policies for Parental, Family and Medical Necessity Leave H-405.960

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may

be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(A-22)

Introduced by: Medical Student Section

Subject: University Land Grant Status in Medical School Admissions

Referred to: Reference Committee C

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1 Whereas, American Indian and Alaska Natives (AI-AN) are defined as “people having origins in
2 any of the original peoples of North America, South America, and Central America, who
3 maintain tribal affiliation or community attachment”[1]; and
4
5 Whereas, The United States Department of Interior Bureau of Indian Affairs recognizes 574
6 American Indian and Alaska Native tribes and villages in the United States, with many more
7 recognized at the state level or in the process of seeking recognition[2]; and
8
9 Whereas, AI-AN communities in the U.S. continue to have lower health status and
10 disproportionate disease burden compared with other Americans, secondary to inadequate
11 education, disproportionate poverty, discrimination in the delivery of health services, and cultural
12 differences with healthcare providers[3]; and
13
14 Whereas, AI-AN individuals born today have a life expectancy that is 5.5 years less than the
15 U.S. all races population (73.0 years to 78.5 years, respectively)[3]; and
16
17 Whereas, The Government Accountability Office reports that 29% of the Indian Health Services’
18 physician positions are vacant, with some regions operating with up to 46% of their physician
19 positions vacant[4]; and
20
21 Whereas, The Association of American Medical Colleges (AAMC) recognizes that the continued
22 underrepresentation of AI-AN physicians should be viewed as a national crisis faced by all
23 medical schools[5]; and
24
25 Whereas, Only 0.56% of active physicians identify as AI-AN alone or in combination with
26 another race, far below their national representation of 2%[1,5]; and
27
28 Whereas, From 2013-2018, greater than 95% of AI-AN tribes (547 / 574) had fewer than 10
29 AI-AN applicants to medical school and 99% of AI-AN tribes (567 / 574) had fewer than 10
30 matriculants to medical school[5]; and
31
32 Whereas, AI-AN medical students are more likely to practice medicine in tribal communities,
33 and are more likely than their peers to practice in underserved areas[5]; and
34
35 Whereas, In a 2016-2017 Curriculum Inventory, the AAMC reported that only 11% of U.S.
36 MD-granting institutions (14 of 131 participating) had AI-AN health content[5]; and

Whereas, Including AI-AN health content in medical school curricula provides visibility to and acknowledges the importance of the health of [AI-AN] communities and prepares all trainees to work with AI-AN communities[5]; and

Whereas, The AAMC recommends the development of focused AI-AN medical education curricula and medical school admissions policies that consider the political identity, rather than solely the race or ethnicity, of American Indians and Alaska Natives from tribal nations[5-6]; and

Whereas, The U.S. Supreme Court has recognized that membership status in a tribe does not violate laws related to non-discrimination or equal protection under the law (i.e., anti-affirmative action laws), iterating that tribal status is distinct from race[6-7]; and

Whereas, The AAMC has recognized that anti-affirmative action laws have impacted AI-AN application and matriculation rates to medical school despite rulings from the U.S. Supreme Court[8]; and

Whereas, There are professional programs that preferentially consider tribal membership in admissions and funding awards, such as UCLA School of Law, UC San Diego, and UC Davis School of Medicine[6,9-10]; and

Whereas, Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded to meet the needs of AI-AN communities (H-350.981); and

Whereas, Our AMA opposes legislation and other related efforts that undermine the ability of institutions to employ affirmative action to promote a diverse student population (D-200.985); and

Whereas, As tribal membership is legally distinct from race, then it follows that tribal membership can be affirmatively considered outside of holistic admissions processes, including those that have race-blind admissions (e.g., California, Washington)[5]; and

Whereas, The federal government has a unique legal and political relationship with Tribal governments established through and confirmed by the United States Constitution, treaties, federal statutes, executive orders, and judicial decisions[11]; and

Whereas, Central to this relationship is the Federal Government's trust responsibility to protect the interests of Indian Tribes and communities[11]; and

Whereas, The federal trust responsibility is a legal obligation under which the federal government "has charged itself with moral obligations of the highest responsibility and trust" toward AI-AN tribes, which include healthcare and education[12-13]; and

Whereas, The federal trust responsibility establishes the basis for a variety of federal services provided to federally recognized tribes and villages, including healthcare delivery and the provision of physicians, on the basis of tribal membership, not racial identification[14]; and

Whereas, Land-grant universities are universities built on land transferred to states from the federal government with the enactment of the Morrill Act of 1862[15-16]; and

Whereas, Land-grant universities, many of which house associated medical schools, continue to derive benefit from 10.7 million acres of land expropriated from nearly 250 tribal nations, while being federal and state government-funded entities[15-16]; and

Whereas, As a creation of the federal government and recipient of federal funding, land-grant universities therefore play a role in the fulfillment of the federal trust responsibility; and

Whereas, The rationale for this policy is supported by the following 29 health and policy-related organizations and AI-AN tribes: American Indian Studies Department, CSUSM, San Marcos, CA, American Indian Studies Department, SDSU, San Diego, CA, Association of American Indian Physicians, Oklahoma City, OK, California Consortium for Urban Indian Health, Sacramento, CA, California Democratic Party Native American Caucus, Sacramento, CA, California Indian Culture and Sovereignty Center, San Marcos, CA, California Rural Indian Health Board, Roseville, CA, Center for Native American Youth, Washington, DC, Coyote Valley Band of Pomo Indians, Redwood Valley, CA, Federated Indians of Graton Rancheria, Rohnert Park, CA, Indian Health Center of Santa Clara Valley, San Jose, CA, Indian Health Council, Valley Center, CA, La Jolla Band of Luiseño Indians, Pauma Valley, CA, Latino Medical Student Association, Chicago, IL, Mesa Grande Band of Mission Indians, Santa Ysabel, CA, National Indian Health Board, Washington, DC, Native American Health Center, Oakland, CA, Pala Band of Mission Indians, Pala, CA, Pauma Band of Luiseño Indians, Pauma Valley, CA, Rincon Band of Luiseño Indians, Valley Center, CA, Sacramento Native American Health Center, Sacramento, CA, San Diego American Indian Health Center, San Diego, CA, San Manuel Band of Mission Indians, Highland, CA, San Pasqual Band of Mission Indians, Valley Center, CA Santa Ynez Band of Chumash Indians, Santa Ynez, CA, Student National Medical Association, Washington, DC Sycuan Band of the Kumeyaay Nation, El Cajon, CA, Tolowa Dee-ni' Nation, Smith River, CA, Wilton Rancheria, Elk Grove, CA[17]; and

Whereas, Medical schools are chiefly responsible for the composition of the physician workforce and set their own admissions criteria[5]; therefore be it

RESOLVED, That our American Medical Association work with the Association of American Medical Colleges, Liaison Committee on Medical Education, Association of American Indian Physicians, and Association of Native American Medical Students to design and promulgate medical school admissions recommendations in line with the federal trust responsibility (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-350.981, "AMA Support of American Indian Health Career Opportunities," by addition to read as follows:

AMA Support of American Indian Health Career Opportunities H-350.981

AMA policy on American Indian health career opportunities is as follows:
(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals. <u>These efforts should include, but are not limited to, priority consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and robust mentorship programs that support the successful advancement of these trainees.</u>
(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for <u>stronger</u> <u>clinical exposure and a greater number of</u> health professionals to work among the American Indian population.
(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.
<u>(5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.</u>
<u>(6) Our AMA will engage with the Association of Native American Medical Students and Association of American Indian Physicians to design and disseminate American Indian and Alaska Native medical education curricula that prepares trainees to serve AI-AN communities.</u> (Modify Current HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Date Received: 04/08/22

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RELEVANT AMA POLICY

AMA Support of American Indian Health Career Opportunities H-350.981

AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals.
(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population.
(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.
CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation: A-12

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.
(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative non-federal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs

of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.
CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation: A-12; Reaffirmed: Res. 233, A-13

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of non-reservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
CLRPD Rep. 2, I-98; Reaffirmed: Res. 22, A-07; Reaffirmation: A-12; Reaffirmed: Res. 233, A-13

Desired Qualifications for Indian Health Service Director H-440.816
Our AMA supports the following qualifications for the Director of the Indian Health Service:
1. Health profession, preferably an MD or DO, degree and at least five years of clinical experience at an Indian Health Service medical site or facility.
2. Demonstrated long-term interest, commitment, and activity within the field of Indian Health.
3. Lived on tribal lands or rural American Indian or Alaska Native community or has interacted closely with an urban Indian community.
4. Leadership position in American Indian/Alaska Native health care or a leadership position in an academic setting with activity in American Indian/ Alaska Native health care.
5. Experience in the Indian Health Service or has worked extensively with Indian Health Service, Tribal, or Urban Indian health programs.

6. Knowledge and understanding of social and cultural issues affecting the health of American Indian and Alaska Native people.
7. Knowledge of health disparities among Native Americans / Alaska Natives, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities.
8. Experience working with Indian Tribes and Nations and an understanding of the Trust Responsibility of the Federal Government for American Indian and Alaska Natives as well as an understanding of the sovereignty of American Indian and Alaska Native Nations.
9. Experience with management, budget, and federal programs.
Res. 603, I-18

Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987
1. Our AMA will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers.
2. Our AMA will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service.
3. Our AMA adopts as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction.
4. In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service.
5. Our AMA will request that Congress: (A) amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; (B) include our recommendation for the Indian Health Service (HIS) Advanced Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations.
Res. 233, A-13; Appended: Res. 229, A-14

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.
Citation: BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, I-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(A-22)

Introduced by: Medical Student Section

Subject: Decreasing Bias in Evaluations of Medical Student Performance

Referred to: Reference Committee C

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1 Whereas, Racism, xenophobia, sexism, homophobia, transphobia, ableism, and other
2 discrimination within medical education manifests through structural, institutional, and
3 interpersonal means, which necessitates a multilevel approach in order to be addressed[1-6]; and
4
5 Whereas, The Liaison Committee on Medical Education (LCME) defines a "fair and formal
6 process for taking any action that may affect the status of a medical student" such that a
7 "...student will be assessed by individuals who have not previously formed an opinion of the
8 student's abilities, professionalism, and/or suitability to become a physician"[7]; and
9
10 Whereas, Differences by race and ethnicity have been documented in receipt of Honors in
11 various clerkships, Alpha Omega Alpha membership, Medical Student Performance Evaluation
12 (MSPE) comments, and the residency application process[8-13]; and
13
14 Whereas, Latinx and Black physicians received a disproportionate number of complaints to the
15 Medical Board of California and had greater odds of complaints escalating to investigations, and
16 Latinx physicians had a greater probability of having an investigation result in disciplinary action
17 in a study of 32,978 complaints to the Medical Board of California between 2003 and 2013[14];
18 and
19
20 Whereas, A study in which fabricated prospective students with names indicative of their gender
21 and race sent emails to professors to discuss research opportunities demonstrated that
22 professors were most responsive to students whose names indicated that they were Caucasian
23 and male, especially professors at private universities and those in more lucrative fields[15]; and
24
25 Whereas, A study of medical students in the Netherlands revealed that non-Dutch students
26 were referred to the professional behavior board at a rate 2.86 times that of Dutch students, and
27 noted that "(cultural) differences in communication styles may be a possible explanation for
28 these students' underperformance" and "more subjective grading in clinical training can lead to
29 what is called 'examiner bias', which means that examiners have a more positive view on
30 people who are similar to themselves"[16]; and
31
32 Whereas, Blinded peer review of scientific abstracts has been found to resolve statistically-
33 significant bias against non-English speaking authors, international institutions, and less
34 prestigious institutions[17]; and
35
36 Whereas, All component groups of the admissions committee of the Ohio State University
37 College of Medicine showed implicit white preference on the Black-White Implicit Association
38 Test, with men and faculty members displaying greater levels of unconscious bias than women
39 and students[18]; and

Whereas, It has been shown implicit bias in grading can be mitigated through the recruitment of diverse disciplinary and grade review committees and through implicit bias awareness training[18-23]; and

Whereas, There is existing literature on the benefits of a two-interval grading system from a wellbeing standpoint, but there are limited published studies delineating the specific impact of this grading schema for minoritized trainees in terms of residency applications and career opportunities[24-26]; and

Whereas, The tiered grading system, often using grades of honors, high pass, pass, fail, or similar, is the most commonly used system for clerkship grading in allopathic US medical schools, while the two-interval, or pass/fail, system is most often used for clerkship grading in osteopathic US medical schools although a number of US allopathic medical schools such as Harvard, University of San Francisco, the David Geffen School of Medicine at UCLA, and the Perelman School of Medicine at the University of Pennsylvania have transitioned to two-tiered systems for at least some of their required clerkships[27-29]; and

Whereas, Inequities present in the tiered grading system have been shown to cascade to subsequent levels of training, leading to the persistent underrepresentation of Black, Latinx/Hispanic, American Indian, Alaska Native, and certain Asian subgroups in medicine[30]; and

Whereas, Two-interval grading and hybrid systems that incorporate pass/fail grades may minimize the disparities in the quantitative aspects of performance evaluations; however, this does not protect from the racial biases codified in the language of medical student performance evaluations as well as other aspects of residency applications, and as such, there is not enough evidence to support or oppose two-interval grading systems for clinical clerkships at this time[31-38]; therefore be it

RESOLVED, That our American Medical Association work with appropriate stakeholders, such as the Liaison Committee on Medical Education and the Commission on Osteopathic College Accreditation to support: 1) increased diversity and implementation of implicit bias training to individuals responsible for assessing medical students' performance, including the evaluation of professionalism and investigating and ruling upon disciplinary matters involving medical students; and 2) that all reviews of medical student professionalism and academic performance be conducted in a blinded manner when doing such does not interfere with appropriate scoring (Directive to Take Action); and be it further

RESOLVED, That our AMA study the impact of two-interval clinical clerkship grading systems on residency application outcomes and clinical performance during residency. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Date Received: 04/08/22

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RELEVANT AMA POLICY

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 identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.

(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.

(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.

(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

Issued: 2016

Fostering Professionalism During Medical School and Residency Training D-295.983

(1) Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements: (a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics.

(b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism.

(c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees' acquisition of professionalism.
(d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism.
(2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism.
CME Rep. 3, A-01; Reaffirmation: I-09; Reaffirmed: CME Rep. 01, A-19; Modified: CME Rep. 01, A-20

11.2.1 Professionalism in Health Care Systems
Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.
Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.
Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.
Formularies, clinical practice guidelines, and other tools intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.
Physicians in leadership positions within health care organizations should ensure that practices for financing and organizing the delivery of care:
(a) Are transparent.
(b) Reflect input from key stakeholders, including physicians and patients.
(c) Recognize that over reliance on financial incentives may undermine physician professionalism.
(d) Ensure ethically acceptable incentives that:
(i) are designed in keeping with sound principles and solid scientific evidence. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles. Practice guidelines, formularies, and other tools should be based on best available evidence and developed in keeping with ethics guidance;
(ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;
(iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;
(iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.
(e) Encourage, rather than discourage, physicians (and others) to:
(i) provide care for patients with difficult to manage medical conditions;
(ii) practice at their full capacity, but not beyond.
(f) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.

(g) Are routinely monitored to:
(i) identify and address adverse consequences;
(ii) identify and encourage dissemination of positive outcomes.
All physicians should:
(h) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.
(i) Advocate for changes in health care payment and delivery models to promote access to high-quality care for all patients.
Issued: 2016

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation: A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(A-22)

Introduced by: Medical Student Section

Subject: Support for Standardized Interpreter Training

Referred to: Reference Committee C

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1 Whereas, There are more than 6,900 known living languages spoken in the world[1]; and
2
3 Whereas, More than 66 million Americans speak at least one of over 350 languages other than
4 English at home and more than 25 million Americans speak English "less than very well"[2-4]; and
5
6 Whereas, Language barriers can have major adverse effects on health such as suboptimal
7 health status; lower likelihood of having regular care providers; lower rates of mammograms,
8 pap smears, and other preventative services; greater likelihood of diagnosis of more severe
9 psychopathology; leaving the hospital against medical advice; and increased risk of drug
10 complications[1,3,5]; and
11
12 Whereas, Ad hoc interpreters have been shown to engage in "false fluency", where substandard
13 interpretation skills leads to inadequate translation, thereby compromising the integrity of the
14 patient-provider interaction[6-8]; and
15
16 Whereas, Errors in medical interpretation are not uncommon, and translation errors made by ad
17 hoc interpreters are more likely to result in clinical consequences than errors made by
18 professionally trained medical interpreters[9]; and
19
20 Whereas, Underuse of a valuable health care resource, professional medical interpretation, can
21 result in these adverse effects and inappropriate care[4]; and
22
23 Whereas, Professional medical interpreter services can facilitate effective communication
24 across language differences and increase the delivery of health care to Limited English
25 Proficiency (LEP) patients, yet remain underutilized in health care[3,10]; and
26
27 Whereas, Language assistance is a legal right of patients under Title VI of the 1964 Civil Rights
28 Act, therefore hospitals have policies and processes in place, but how they are communicated
29 to front-line staff is variable[5,11]; and
30
31 Whereas, One potential contributor is the lack of a designated place within medical training
32 curricula to address language barriers, which calls for a more recognizable and accessible
33 resource for training[5,11]; and
34
35 Whereas, In recent studies, only 19% of emergency department (ED) staff had reported prior
36 training on working with interpreters, regardless of the source of training[7], and most ED
37 providers and staff who have little training in the use of language assistance were unaware of
38 hospital policy in this area[11,12]; and

Whereas, Only 28% of medical schools offer students on clerkships training involving a language interpreter[13]; and

Whereas, Dissemination of best practices for the provision of language assistance and the clinical use of non-English language skills has the potential to improve communication with LEP patients[11]; and

Whereas, Healthcare organizations should ensure that medical professionals across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery or have access to training[14]; and

Whereas, Providing training to physicians and medical students about the proper use of medical interpreter services increases the correct use of those services[15-18]; and

Whereas, Teaching medical professionals to emphasize the appropriate use of an interpreter is warranted to improve cross-language clinical encounters, and could be executed through a Continuing Medical Education (CME) module[12]; and

Whereas, It has been recommended that healthcare organizations should either verify that staff at all levels and in all disciplines participate in ongoing CME-accredited education or other training in Culturally and Linguistically Appropriate Services delivery, or arrange for such education and training to be made available to staff[14]; and

Whereas, CME is a cornerstone of improving competencies and ensuring high-quality patient care by nurses and physicians[19]; and

Whereas, Although the AMA Education Hub (EdHub) has produced a series of modules related to Health Disparities and the Health Care Workforce, such as Disparities in Research and Health Equity to Bias in Artificial Intelligence, it does not currently have any modules covering the correct use of interpreter services; and

Whereas, The American Association of Medical Colleges (AAMC) has published “Guidelines on the Use of Medical Interpreter Services,” which describe best practices for assessing English proficiency, use of an interpreter, additional considerations for ad hoc interpreters, conflicts of interest and privacy, and considerations for telephonic interpreter services[20]; and

Whereas, Though AMA policy reimbursement for and calls for further research regarding interpreter services (D-385.957, H-160.924, H-385.928, H-382.929, D-385.978), it does not recognize the importance of interpreter services for providing appropriate care or call upon physicians to use them with patients with LEP, and the AMA Ed Hub does not currently provide any resources addressing how to correctly use interpreter services; therefore be it

RESOLVED, That our American Medical Association recognize the importance of using medical interpreters as a means of improving quality of care provided to patients with Limited English Proficiency (LEP) including patients with sensory impairments (New HOD Policy); and

RESOLVED, That our AMA encourage physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the American Association of Medical College’s “Guidelines for Use of Medical Interpreter Services” (New HOD Policy); and be it further

1 RESOLVED, That our AMA work with the Commission for Medical Interpreter Education,
2 National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians,
3 National Medical Association, Association of American Indian Physicians, and other relevant
4 stakeholders to develop a cohesive Continuing Medical Education module offered through the
5 AMA Ed Hub for physicians to effectively and appropriately use interpreter services to ensure
6 optimal patient care. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Date Received: 04/08/22

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RELEVANT AMA POLICY

Certified Translation and Interpreter Services D-385.957

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.
Res. 703, A-17; Reaffirmed: CMS Rep. 7, A-21

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924
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.
BOT Rep. 8, I-02; Reaffirmation: I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation: A-09; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17

Patient Interpreters H-385.928
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.
Res. 219, I-01; Reaffirmed: BOT Rep. 8, I-02; Reaffirmation: I-03; Reaffirmed in lieu of Res .722, A-07; Reaffirmation: A-09; Reaffirmation: A-10; Reaffirmation A-14

Availability and Payment for Medical Interpreters Services in Medical Practices H-385.929
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.
BOT Rep. 25, I-01; Reaffirmation: I-03; Reaffirmed: Res. 907, I-03; Reaffirmation: A-09; Reaffirmation: A-17

Language Interpreters D-385.978
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.
Res. 907, I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation: A-09; Reaffirmation: A-10; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(A-22)

Introduced by: Illinois

Subject: Discontinue State Licensure Requirement for COMLEX Level 2 PE

Referred to: Reference Committee C

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1 Whereas, The National Board of Medical Examiners (NBME) announced in late January the
2 cancellation of the USMLE Step 2 Clinical Skills examination, soon after the AMA had adopted a
3 resolution encouraging USMLE Step 2 Clinical Skills and COMLEX Level 2 PE to be eliminated
4 and replaced by examinations administered by accredited medical schools[1]; and
5
6 Whereas, The usefulness of these examinations for graduates of U.S. and Canadian medical
7 schools is questionable, given that North American medical students passed the USMLE Step 2
8 examination with a rate of 98% whereas by contrast medical students attending school outside
9 North America have a pass rate of 79%[2]; therefore be it
10
11 RESOLVED, That our American Medical Association advocate to remove COMLEX Level 2 PE
12 as a requirement for state medical licensure for graduates of accredited U.S. and Canadian
13 osteopathic medical schools, and encourage state medical societies to do the same for their
14 state licensure bodies. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

References:
1. Murphy B. USMLE Step 2 CS canceled: What it means for medical students. American Medical Association. https://www.ama-assn.org/residents-students/usmle/usmle-step-2-cs-canceled-what-it-means-medical-students. Published February 4, 2021.
2. Lehman EP 4th, Guercio JR. The Step 2 Clinical Skills exam--a poor value proposition. N Engl J Med. 2013;368(10):889-891. doi:10.1056/NEJMp1213760
3. Gesundheit, Neil MD, MPH A Crisis of Trust Between U.S. Medical Education and the National Board of Medical Examiners, Academic Medicine: September 2020 - Volume 95 - Issue 9 - p 1300-1304 doi: 10.1097/ACM.0000000000003131

RELEVANT AMA POLICY

Potential Impact of the USMLE Step 2 CS and COMLEX-PE on Undergraduate and Graduate Medical Education D-275.981
Our AMA will: (1) continue to closely monitor the USMLE Step 2 CS and the COMLEX-USA Level 2-PE, collecting data on initial and final pass rates, delays in students starting residency training due to scheduling of examinations, economic impact on students, and the potential impact of ethnicity on passing rates; and (2) encourage residency program directors to proactively evaluate their access to resources needed to assist resident physicians who have not passed these examinations to remediate.
Citation: (CME Rep. 4, A-04; Modified: CME Rep. 2, A-14)

Clinical Skills Assessment During Medical School D-295.988

1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.
2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.
3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.
4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.
5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.
6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.
7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.

Citation: CME Rep. 7, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: Alt. Res. 311, A-16; Appended: CME Rep. 9, A-17; Reaffirmation: I-19; Reaffirmed: Res. 306, I-20; Reaffirmed in lieu of: Res. 308, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(A-22)

Introduced by: Illinois

Subject: Reduce Financial Burden to Medical Students of Medical Licensure Examinations

Referred to: Reference Committee C

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1 Whereas, The National Board of Medical Examiners (NBME) and Federation of State Medical
2 Boards (FSMB) require medical students and residents to purchase four examinations in order
3 to complete their training; and
4
5 Whereas, The purchase of these examinations with loan money substantially increases the
6 amount paid by trainees; and
7
8 Whereas, The cost of the Step 2 Clinical Skills examination alone costs medical students in the
9 United States and Canada $20.4 million per annum, which increases to $56.4 million at
10 compounded interest at a rate of 6.8%; and
11
12 Whereas, The standard inflation discount rate of 3% adjusts the 15-year cost of the Step 2
13 Clinical Skills examination to $36.2 million annually in 2012; and
14
15 Whereas, The median student debt accrued at graduation has increased by 220% from 1992 to
16 2017 after accounting for inflation for medical students in the United States from $50,000 in
17 1992 and rising to $192,000 in 2017; and
18
19 Whereas, Increasing level of medical student debt level is associated with poor academic
20 performance and mental health, as well as alcohol abuse and dependence; therefore be it
21
22 RESOLVED, That our American Medical Association advocate for medical licensure
23 examinations and related study, practice examinations, and examination preparatory materials
24 released by the National Board of Medical Examiners and the National Board of Osteopathic
25 Medical Examiners to be available at a cost that does not exceed the reasonable cost of
26 providing the examination and examination preparatory materials. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

References:

1. Lehman EP 4th, Guercio JR. The Step 2 Clinical Skills exam--a poor value proposition. *N Engl J Med*. 2013;368(10):889-891. doi:10.1056/NEJMp1213760
2. Pisaniello MS, Asahina AT, Bacchi S, et al. Effect of medical student debt on mental health, academic performance and specialty choice: a systematic review. *BMJ Open*. 2019;9(7):e029980. Published 2019 Jul 2. doi:10.1136/bmjopen-2019-029980
3. Gesundheit N. A Crisis of Trust Between U.S. Medical Education and the National Board of Medical Examiners [published online ahead of print, 2019 Dec 17]. *Acad Med*. 2019;10.1097/ACM.0000000000003131.

RELEVANT AMA POLICY

Clinical Skills Training in Medical Schools D-295.960

Our AMA: (1) encourages medical schools to reevaluate their educational programs to ensure appropriate emphasis of clinical skills training in medical schools; (2) encourages medical schools to include longitudinal clinical experiences for students during the "preclinical" years of medical education; (3) will evaluate the cost/value equation, benefits, and consequences of the implementation of standardized clinical exams as a step for licensure, along with the barriers to more meaningful examination feedback for both examinees and US medical schools, and provide recommendations based on these findings; and (4) will evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills exam and their implications for US medical students and international medical graduates.
Citation: (Res. 324, A-03; Appended: Res. 309, A-11; Appended: Res. 904, I-13)

Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934

Our AMA adopts the following principles:
(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training.
(2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all state-required licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement for completing one year of accredited GME in the U.S.: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.
(3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA.
(4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians.
(5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements.
(6) There should be no reporting of actions against medical students to state medical licensing boards.
(7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills.
(8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.
Citation: CME Rep. 8, A-99; Reaffirmed: CME Rep. 4, I-01; Reaffirmed: CME Rep. 2, A-11; Modified: CME Rep. 2, A-12; Modified: CME Rep. 2, A-21

Independent Regulation of Physician Licensing Exams D-295.939
Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system; (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX).
Citation: CME Rep. 10, A-08; Modified: CME Rep. 01, A-18

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of

their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial

planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21

Clinical Skills Assessment During Medical School D-295.988
1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what

constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.
2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.
3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.
4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.
5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.
6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.
7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.
Citation: CME Rep. 7, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: Alt. Res. 311, A-16; Appended: CME Rep. 9, A-17; Reaffirmation: I-19; Reaffirmed: Res. 306, I-20; Reaffirmed in lieu of: Res. 308, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(A-22)

Introduced by: Illinois, American Society of Anesthesiologists

Subject: Decreasing Medical Student Debt and Increasing Transparency in Cost of Medical School Attendance

Referred to: Reference Committee C

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1 Whereas, 73% of 2019 medical school graduates reported having educational debt, with a
2 median reported debt being $200,000[1]; and
3
4 Whereas, Education debt levels have been increasing at a rate higher than inflation over the
5 past decade, and grants and scholarships rarely cover the entire cost of medical school
6 attendance[1]; and
7
8 Whereas, Texas medical schools have decreased the costs of education through establishing a
9 state-wide tuition cap law for state residents[2], and NYU Langone School of Medicine has been
10 able to eliminate student tuition through donor funds[3]; therefore be it
11
12 RESOLVED, That our American Medical Association work with Congress and related bodies to
13 make it a priority to reduce the costs of medical school tuition incurred by graduates of U.S.
14 medical schools, without sacrificing current educational quality (Directive to Take Action); and
15 be it further
16
17 RESOLVED, That our AMA encourage the written transparent disclosure by U.S. medical
18 schools of the overall cost of attendance, including but not limited to, cost of living; educational
19 materials not provided by the school, such as exam preparatory materials from outside
20 companies; examination fees; interview and residency application costs; and other related costs
21 incurred by students over the duration of their education (New HOD Policy); and be it further
22
23 RESOLVED, That our AMA encourage the written transparent disclosure of all scholarships
24 provided by an institution, including disclosure of allocation criteria and duration (New HOD
25 Policy); and be it further
26
27 RESOLVED, That our AMA encourage U.S. medical schools to provide written, transparent
28 information about how medical school tuition dollars are allocated across the medical school
29 budget. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

References:

1. Youngclaus J & Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. AAMC. 2020.
2. Texas Education Code § 54
3. NYU School of Medicine offers full-tuition scholarships to all new & current medical students [news release]. New York: NYU Langone Health; August 16, 2018. https://nyulangone.org/press-releases/nyu-school-of-medicine-offers-full-tuition- scholarships-to-all-new-current-medical-students. Accessed October 22, 2020.

RELEVANT AMA POLICY

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for

medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that

all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician

shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the

current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep, 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19; Reaffirmed: CME Rep. 3, A-21

Residency Interview Costs H-310.966
1. It is the policy of the AMA to pursue changes to federal legislation or regulation, specifically to the Higher Education Act, to include an allowance for residency interview costs for fourth-year medical students in the cost of attendance definition for medical education.
2. Our AMA will work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, in consideration of the following strategies to address the high cost of interviewing for residency/fellowship: a) establish a method of collecting data on interviewing costs for medical students and resident physicians of all specialties for study, and b) support further study of residency/fellowship interview strategies aimed at mitigating costs associated with such interviews.
Citation: (Res. 265, A-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10; Appended: Res. 308, A-15)

Minorities in the Health Professions H-350.978
The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.
(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.

(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.
(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.
(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.
(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.
(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.
(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program.
Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314
(A-22)

Introduced by: Medical Student Section

Subject: Support for Institutional Policies for Personal Days for Undergraduate Medical Students

Referred to: Reference Committee C

Whereas, Burnout is a multifactorial occupational syndrome characterized by emotional exhaustion, depersonalization, and cynicism or professional dissatisfaction as a result of prolonged stress[1,2]; and

Whereas, Burnout can not only undermine professional development, but also contribute to mental health disorders including suicidal ideation and substance use[2]; and

Whereas, Over half of U.S. medical students report experiencing burnout at some point in their medical education, along with greater prevalence of depressive symptoms (27.2%) and suicidal ideation (11.1%) compared to the general population (7.1% and 4%, respectively)[2-4]; and

Whereas, A lack of protected time remains the prominent barrier preventing medical students from accessing mental health treatment[5]; and

Whereas, Institutional policies and initiatives to address burnout and improve mental wellness vary widely, including the implementation of “sick days” which may require proof of illness or be restricted in how they can be utilized[6,7]; and

Whereas, Students may not feel comfortable sharing mental health concerns due to professional stigma, shame, or fear or repercussions on professional development[8]; and

Whereas, Personal days are defined as excused absences that may require advance notice but without an explanation for the absence, and may also be utilized for mental wellness, physical wellness, and self-care[9]; and

Whereas, Personal days have been increasingly prevalent in workplace or corporate policies, and are now offered in over one third of workplaces and in companies such as Netflix, Best Buy, and Virgin America[10,11]; and

Whereas, The implementation of personal days in medical schools would allow students to address their health needs--including mental health and routine appointments--without compromising their privacy to clerkship directors or administrators; and

Whereas, A number of medical schools have started providing personal days, though policies continue to vary widely due to lack of standardization[12-31]; and

Whereas, Our AMA has policy supporting existing programs in identification and management of stress (H-405.957), prioritizing self-care among medical students and the maintenance of a healthy lifestyle (H-405.957), and promoting the recognition of burnout in students by

institutional officials, program directors, resident physicians, and attending faculty (H-295.858); therefore be it

RESOLVED, That our American Medical Association encourage medical schools to accept flexible uses for excused absences from clinical clerkships (New HOD Policy); and be it further

RESOLVED, That our AMA support a clearly defined number of easily accessible personal days for medical students per academic year, which should be explained to students at the beginning of each academic year and a subset of which should be granted without requiring an explanation on the part of the students. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

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RELEVANT AMA POLICY

Access to Confidential Health Services for Medical Students and Physicians H-295.858

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.

4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6.Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
7.Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
Citation: CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18; Reaffirmed: BOT Rep. 15, A-19

Programs on Managing Physician Stress and Burnout H-405.957
1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.
Citation: Res. 15, A-15; Appended: Res. 608, A-16; Reaffirmed: BOT Rep. 15, A-19

Study of Medical Student, Resident, and Physician Suicide D-345.983
Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; and (4) collaborate with other stakeholders to study the incidence of and risk factors for depression,

substance misuse and addiction, and suicide among physicians, residents, and medical students.
Citation: CME Rep. 06, A-19

Physician and Medical Student Burnout D-310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
Citation: CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(A-22)

Introduced by: Medical Student Section

Subject: Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program

Referred to: Reference Committee C

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1 Whereas, The American College Application Service (AMCAS) is the American Association of
2 Medical College's (AAMC) centralized medical school application processing service and is
3 used by most US medical schools as the primary application method for their entering class[1];
4 and
5
6 Whereas, The 2019 medical school application fee through AMCAS is $170 for the first
7 application and an additional $40 for each application after[2]; and
8
9 Whereas, It is estimated that the average cost of secondary applications is $80 per application,
10 and pre-medical applicants apply to an average of 16 medical schools per cycle[3,4]; and
11
12 Whereas, Pre-medical students without AAMC Fee Assistance Program (FAP) benefits spend
13 at least $2,800 on application fees alone, not including travel costs for interviews[5]; and
14
15 Whereas, Spending $2,800 on application fees alone would be four times greater than the
16 amount the median US household saves for miscellaneous fees in their budget[6]; and
17
18 Whereas, The Medical College Admission Test (MCAT), developed and administered by the
19 AAMC, is a standardized, multiple-choice examination created to help medical school
20 admissions offices assess students[7]; and
21
22 Whereas, The cost of MCAT registration is $315, with additional fees for late registration and
23 changing test dates, not including test-prep materials recommended to most students which are
24 offered by the AAMC and other test-prep companies[9]; and
25
26 Whereas, The University of California Berkeley Career Center estimates a total cost of
27 approximately $7,520 total for the medical school application process as of 2014, and notes that
28 the cost is higher for those applying to both allopathic and osteopathic programs[10]; and
29
30 Whereas, The AAMC generated over $70 million dollars in revenue by administering the MCAT
31 and AMCAS alone in 2016[8]; and
32
33 Whereas, The Fee Assistance Program (FAP), offered by AAMC, exists to assist those who,
34 without financial assistance, would not be able to apply to medical schools who use the AMCAS
35 application and would not be able to afford the MCAT registration fee[9]; and
36
37 Whereas, In order to qualify for the 2019 FAP, the applicants' total family income in 2018 must
38 be 300% or less than the 2018 national poverty level for that family size[11]; and

Whereas, In contrast to other federally funded programs, the FAP does not distinguish between independent or dependent tax statuses, and therefore, parental financial information and tax documents are required and must also fall within eligibility guidelines; this requirement is not waived based on marital status, age or tax filing status[11]; and

Whereas, An applicant having an income that meets the eligibility requirements for fee assistance will still be denied assistance based on parental income[11]; and

Whereas, The Free Application for Federal Student Aid (FAFSA) provided for by the U.S. Department of Education does not require an applicant to report parental income if they file taxes as an independent[12]; and

Whereas, The Expected Family Contribution (EFC) is an index number used by the FAFSA based on family's taxed and untaxed income, assets, and benefits to generate a sliding-scale model in which a lower EFC indicates eligibility for more financial aid[13]; and

Whereas, Offering additional need-based aid to students increases the odds of obtaining their degree, thus helping to reduce inequality in higher education[14]; and

Whereas, In 2017, less than 5% of entering medical students came from the lowest quintile of family income while 51% came from the highest quintile[15]; and

Whereas, Despite several efforts to make medical education attainable to low-income students, the cost of attending medical school continues to rise, making it even more difficult for low-income students and families to afford in the future[16]; and

Whereas, Our AMA has pledged to take action on the rising cost of medical education and its contribution to student debt (H-305.925); and

Whereas, Our AMA has established support for increasing the representation of minority and economically disadvantaged populations in the medical profession (H-350.979) and has committed to working with the AAMC to achieve this goal (D-200.985); therefore be it

RESOLVED, That our American Medical Association encourage the Association of American Medical Colleges to conduct a study of the financial impact of the current Fee Assistance Program policy to medical school applicants. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

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RELEVANT AMA POLICY

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
(4) Increasing the supply of minority health professionals.
(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.
Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty

members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to

permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making

permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21

Cost and Financing of Medical Education and Availability of First-Year Residency Positions H-305.988
Our AMA:
1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
6. supports continued study of the relationship between medical student indebtedness and career choice;
7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.
Citation: CME Rep. A, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Res. 313, I-95; Reaffirmed by CME Rep. 13, A-97; Modified: CME Rep. 7, A-05; Modified: CME Rep. 13, A-06; Appended: Res. 321, A-15; Reaffirmed: CME Rep. 05, A-16; Modified: CME Rep. 04, A-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(A-22)

Introduced by: Illinois

Subject: Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools

Referred to: Reference Committee C

Whereas, The racial and ethnic data for matriculants of United States medical schools shows that Black, Hispanic, and American Indian or Alaska Native populations are underrepresented in medical schools when compared to the general population, despite the implementation of Liaison Committee on Medical Education (LCME) diversity accreditation guidelines in 2009; and

Whereas, A study comparing Association of American Medical Colleges (AAMC) faculty data between 1990 and 2016 found that Blacks and Hispanics are more underrepresented in the faculty for sixteen medical specialties in 2016 than they were in 1990 with the exception of Black females in obstetrics and gynecology; and

Whereas, Racial and ethnic population differences between medical students and physicians and the populations that they serve lead to health disparities in underrepresented minorities (URM); and

Whereas, Results of a systematic review on implicit bias among healthcare providers suggests that implicit bias against African Americans, Hispanics and other people of color is present among many health care providers of different specialties, levels of training, and levels of experience; and

Whereas, Recruitment and retention of URM faculty members, mentors, and teachers have shown to improve the educational experiences of all medical students and residents, and by extension the quality of patient care in diverse populations; and

Whereas, A study looking at successful strategies of URM faculty recruitment and retention showed that institutional support for underrepresented minorities and awareness of diversity climate is a successful strategy; and

Whereas, The most common reason for underrepresentation of minorities in medicine is lack of a welcoming environment and role models with whom they can identify, and transparent data will allow applicants to evaluate the diversity climate of the institution; and

Whereas, AAMC provides racial and ethnic data of applicants and matriculants to medical schools by year and state, however does not break this data down for individual medical schools; and

Whereas, AAMC provides transparent medical school faculty data including rank, sex, department, and race, however this is not broken down for individual medical schools; therefore be it

1 RESOLVED, That our American Medical Association work with the Liaison Committee on
2 Medical Education and Commission on Osteopathic College Accreditation to encourage their
3 respective accredited medical schools to make publicly available without charge transparent
4 and accurately reported race and ethnicity demographic data regarding students and faculty.
5 (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 05/02/22

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RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979
Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
(4) Increasing the supply of minority health professionals.
(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.
Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 317
(A-22)

Introduced by: Illinois

Subject: Medical Student, Resident and Fellow Suicide Reporting

Referred to: Reference Committee C

Whereas, Depression is a known risk factor for suicide; and

Whereas, 27% of medical students screen positive for depression, a rate 2.2-5.2 times higher than the age-matched general population; and

Whereas, A meta-analysis reported that 29% of residents screen positive for depression, a rate higher than the general population; and

Whereas, There are no studies assessing fellow depressive symptoms across multiple specialties, though a single survey assessing United States (U.S.) pulmonary and critical care medicine fellows reports that 41% show depressive symptoms; and

Whereas, A relationship that meets causal criteria exists between burnout and suicidal ideation in medical trainees; and

Whereas, Burnout is defined in the *11th Revision of the International Classification of Diseases (ICD-11)* as a syndrome resulting from chronic workplace stress, that has not been successfully managed, and is characterized by feelings of exhaustion, increased cynicism related to the profession, and reduced professional efficacy; and

Whereas, Medical students, residents and fellows report higher rates of burnout than the general population; and

Whereas, The presence of an anxiety disorder is an independent risk factor for suicidal ideation; and

Whereas, Medical students have significantly higher rates of anxiety than the general population; and

Whereas, Residents and fellows are 800% more likely to screen positive for generalized anxiety than the general population; and

Whereas, Over 11% of medical students report experiencing suicidal ideation, yet only three research articles have been published exclusively surveying and collecting data on national medical student suicide rates; and

Whereas, The only published study investigating suicide rates among trainees in Accreditation Council for Graduate Medical Education (ACGME)-Accredited Residency Programs states that the second leading cause of death among residents is suicide; and

Whereas, There are currently no studies reporting suicide rates among U.S. fellowship programs; and

Whereas, There is a general lack of published data on medical student, resident and fellow suicide rates; and

Whereas, AMA Policy D-345.983 urges the Association of American Medical Colleges (AAMC) and ACGME to privately collect data for research on the prevention of future medical trainee suicides; and

Whereas, Council on Medical Education Report 6, A-19, recognizes the limitations of National Death Index (NDI) retrospective data collection, stating, “Studies have shown that suicide is likely under-reported due to a lack of systematic approaches to reporting and assessing the statistics,” and further states the AMA is exploring potential new mechanisms for data collection; and

Whereas, Response bias, listed as a common study design limitation, resulted in underreporting of suicides in the two most recent national medical student suicide survey reports conducted from 1989-1994 and 2006-2011; and

Whereas, Data published attempting to quantify medical student, resident, and fellow suicide is inconsistent because there is no reliable, systematic reporting mechanism for medical trainee suicide; and

Whereas, Lack of consistent published data on medical trainee suicide necessitates a national standardized reporting mechanism and protocol; and

Whereas, Centralized data registries have been found to be beneficial for epidemiologic research initiatives due to the ability to collect prospective, tailorable data that can be stratified to aid with pattern recognition, and a similar system could be beneficial for medical trainee suicides; and

Whereas, Laitman et al (2019) call for reporting of “... numbers of deaths by school, [that] should be publicly available on the AAMC and ACGME websites”; and

Whereas, The AMA has no policy regarding standardized reporting of medical student, resident and fellow suicide information to a publicly accessible database; therefore be it

RESOLVED, That our American Medical Association amend Policy D-345.983 by addition to read as follows:

Study of Medical Student, Resident, and Physician Suicide D-345.983

Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; ~~and~~ (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents, and medical students~~.~~ ; (5) work with appropriate stakeholders to develop a standardized reporting mechanism for the confidential collection of pertinent suicide information of trainees in medical schools, residency, and fellowship programs, along with current wellness initiatives, to inform and promote meaningful interventions at these institutions; and (6) create a publicly accessible database that stratifies medical institutions based on relative rate of trainee suicide over a period of time, in order to raise awareness and promote the implementation of initiatives to prevent medical trainee suicide, while maintaining confidentiality of the deceased. (Modify Current HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 05/02/22

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RELEVANT AMA POLICY

Study of Medical Student, Resident, and Physician Suicide D-345.983
Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; and (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents, and medical students.
Citation: CME Rep. 06, A-19

Access to Confidential Health Services for Medical Students and Physicians H-295.858
1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or

relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6.Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
7.Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
Citation: CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18; Reaffirmed: BOT Rep. 15, A-19

Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians H-345.973
Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place.
Citation: Res. 915, I-15; Revised: CME Rep. 01, I-16

Educating Physicians About Physician Health Programs and Advocating for Standards D-405.990
Our AMA will:
(1) work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory;
(2) continue to collaborate with relevant organizations on activities that address physician health and wellness;
(3) in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs;
(4) work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training;
(5) continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review

(PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; and (6) continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options.
Citation: Res. 402, A-09; Modified: CSAPH Rep. 2, A-11; Reaffirmed in lieu of Res. 412, A-12; Appended: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed: BOT Rep. 15, A-19; Modified: Res. 321, A-19

Residents and Fellows' Bill of Rights H-310.912
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:
RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
Residents and fellows have a right to:
A. An education that fosters professional development, takes priority over service, and leads to independent practice.
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.
D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.
E. Adequate compensation and benefits that provide for resident well-being and health.
(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.
F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.
G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.
With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11.The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.
12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.
Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21

Reference Committee D

BOT Report(s)

15 Addressing Public Health Disinformation

CSAPH Report(s)

01 Council on Science and Public Health Sunset Review of 2012 HOD Policies

02 Transformation of Rural Community Public Health Systems

Resolution(s)

401 Air Quality and the Protection of Citizen Health

402 Support for Impairment Research

403 Addressing Maternal Discrimination and Support for Flexible Family Leave

404 Weapons in Correctional Healthcare Facilities

405 Universal Childcare and Preschool

406 COVID-19 Preventive Measures for Correctional Facilities: AMA Policy Position

407 Study of Best Practices for Acute Care of Patients in the Custody of the Law

408 Supporting Increased Research on Implementation of Nonviolent De-escalation Training and Mental Illness Awareness in Law Enforcement

409 Increasing HPV Vaccination Rates in Rural Communities

410 Increasing Education for School Staff to Recognize Prodromal Symptoms of Schizophrenia in Teens and Young Adults to Increase Early Intervention

411 Anonymous Prescribing Option for Expedited Partner Therapy

412 Advocating for the Amendment of Chronic Nuisance Ordinances

413 Expansion on Comprehensive Sexual Health Education

414 Improvement of Care and Resource Allocation for Homeless Persons in the Global Pandemic

415 Creation of an Obesity Task Force

416 School Resource Officer Violence De-Escalation Training and Certification

417 Tobacco Control

418 Lung Cancer Screening Awareness

419 Advocating for the Utilization of Police and Mental Health Care Co-Response Teams for 911 Mental Health Emergency Calls

REPORT 15 OF THE BOARD OF TRUSTEES (A-22)
Addressing Public Health Disinformation
(Reference Committee D)

EXECUTIVE SUMMARY

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.

DISCUSSION. Disinformation is false or misleading information of which the author knows to be wrong and intends to cause harm. Health professionals are trusted messengers and the spread of disinformation by a few has implications for the entire profession. 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.

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.

This report discusses the impact of disinformation disseminated by health professional, provides an overview of the ways that disinformation is spread including through social media platform and traditional media, reviews the impact of peer-reviewed journals and preprints, and examines incentives for spreading disinformation. The report also provides an overview of the authority of health professional licensing and credentialing boards in addressing disinformation.

CONCLUSION. 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 of this report. 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.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-A-22

Subject: Addressing Public Health Disinformation

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee D

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

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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 measle 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 Medicine[83], the American Board of Pathology[84] and a joint statement by the American Boards of Family Medicine, Internal Medicine and Pediatrics[85] 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 Luján (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~~. (Modify Current HOD Policy)

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 (Reaffirm HOD Policy).

Fiscal Note: $100,000

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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.	• 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.	• 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.	• 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.	• 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.	• 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.	• 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.	• 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. • 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.	• Partner with community groups and other local organizations to prevent and address health disinformation.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-A-22

Subject: Council on Science and Public Health Sunset Review of 2012 House Policies

Presented by: Alexander Ding, MD, MS, MBA, Chair

Referred to: Reference Committee D

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

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

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

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

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

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

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

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RECOMMENDATION

The Council on Science and Public Health recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: $1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-100.971	Physician Awareness and Education About Pharmaceutical and Biological Risk Evaluation and Mitigation	Our AMA will: (1) work with the pharmaceutical and biological industries to increase physician awareness of Risk Evaluation and Mitigation Strategies (REMS) as a means to improve patient safety; and (2) work with the e-prescribing and point of care resource industries to increase physician awareness of REMS as a means to improve patient safety by including current Risk Evaluation and Mitigation Strategy information in their products. (Res. 521, A-12)	Retain; still relevant.
D-115.990	Prescription Container Labeling	1. Our AMA will work with relevant organizations to improve prescription labeling for visually or otherwise impaired patients and to increase awareness of available resources. 2. Our AMA will encourage state Boards of Pharmacy to adopt the ~~newly revised~~ standards contained in the United States Pharmacopeia general chapter on prescription container labeling, which offers specific guidance on how prescription labels should be organized in a patient-centered manner. (Res. 914, I-08; Appended: Res. 904, I-12)	Retain as amended. USP standards were last updated in 2020.
D-120.950	Use of Atypical Antipsychotics in Pediatric Patients	Our AMA will: (1) urge the National Institute of Mental Health to assist in developing guidance for physicians on the use of atypical antipsychotic drugs in pediatric patients; and (2) encourage and support ongoing federally funded research, with a focus on long term efficacy and safety studies, on the use of antipsychotic medication in the pediatric population. (CSAPH Rep. 1, I-12)	Retain, still relevant.
D-130.974	Emergency Preparedness	Our AMA (1) encourages state and local public health jurisdictions to develop and periodically update, with public and professional input, a comprehensive Public Health Disaster Plan specific to their locations. The plan should: (a) provide for special populations such as children, the indigent, and the disabled; (b) provide for anticipated public health needs of the affected and stranded communities including disparate, hospitalized and institutionalized populations; (c) provide for appropriate coordination and assignment of volunteer physicians; and (d) be deposited in a timely manner with the ~~Federal Emergency Management Agency, the Public Health Service, the~~ Department of Health and Human Services, the Department of Homeland	Retain; as amended to reference the Departments of Homeland Security and Health and Human Services and other appropriate federal agencies rather than specifying all relevant agencies within these two departments.

		Security and other appropriate federal agencies; and (2) encourages the Federation of State Medical Boards to implement a clearinghouse for volunteer physicians (MDs and DOs) that would (a) validate licensure in any state, district or territory to provide medical services in another distressed jurisdiction where a federal emergency has been declared; and (b) support national legislation that gives qualified physician volunteers (MDs and DOs), automatic medical liability immunity in the event of a declared national disaster or federal emergency. (Sub. Res. 803, I-05; Reaffirmation A-06; Reaffirmed: BOT Rep. 2, A-07; Reaffirmed in lieu of Res. 938, I-11; Modified: BOT action in response to referred for decision Res. 415, A-12)	
D-135.977	Synthetic Gasification	Our AMA supports ~~will encourage~~ the study of the health effects of clean coal technologies including synthetic gasification plants. (Res. 514, A-12)	Retain as amended and change to H-policy.
D-425.992	Recommendations by the USPSTF	Our AMA will express concern regarding recent recommendations by the United States Preventive Services Task Force (USPSTF) on screening mammography and prostate specific antigen (PSA) screening and the effects these USPSTF recommendations have on limiting access to preventive care for Americans and will encourage the USPSTF to implement procedures that allow for meaningful input on recommendation development from specialists and stakeholders in the topic area under study. (Res. 517, A-12)	Rescind, accomplished. These screenings are also addressed by Policy H-525.993,"Screening Mammography," and Policy H-425.980, "Screening and Early Detection of Prostate Cancer." Existing policy also addresses physician engagement in expert panels (See. H-410.955 and H-410.967 included below).
D-440.938	Triclosan Antimicrobials	Our AMA will encourage the Food and Drug Administration to finalize the triclosan antimicrobial monograph first drafted in 1978 and updated in 1994 which found evidence for the safety and effectiveness of only alcohol and iodine-based topical products in health care use and will encourage the education of members on the issue of the importance of proper hand hygiene and the preferential use of plain soap and water or alcohol-based hand sanitizers in health care settings, consistent with the recommendations of the Centers for Disease Control and Prevention. (Res. 513, A-12)	Rescind. The FDA has issued a final rule (82 FR 60474) and established in 21 CFR 310 that Triclosan among other ingredients are not recognized as safe and effective,

D-440.999	Chemical Analysis Report of Public and Commercial Water	Our AMA: (1) requests the appropriate federal agency to require analysis and appropriate labeling of the chemical content, including fluoride, of commercially bottled water, as well as of the water supplies of cities or towns; (2) urges the FDA to require that annual water quality reports from bottled water manufacturers be publicly accessible in a readily available format; and (3) urges the FDA to evaluate bottled water for changes in quality after typical storage conditions. (Res. 427, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 3, A-12)	Retain; still relevant.
D-470.993	Government to Support Community Exercise Venues	Our AMA ~~will~~ encourages: (1) towns, cities and counties across the country to make recreational exercise more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational fitness facilities; and (2) governmental incentives such as tax breaks and grants for the development of community recreational fitness facilities. (Res. 423, A-04; Reaffirmed in lieu of Res. 434, A-12)	Retain as amended and change to an H policy.
D-480.977	Medical Device "Use Before Dates"	Our AMA will encourage the US Food and Drug Administration to clearly define and interpret the definition and meaning of the "use before date" for medical devices. (Res. 508, A-12)	Retain, still relevant.
D-95.978	Public Service Announcements to Educate Children and Adults to Never to Use Medications Prescribed to Other Individuals	Our AMA ~~will~~ encourages interested stakeholders, federal agencies and pharmaceutical companies to develop public service announcements for television and other media to educate children and adults about the dangers of taking medications that are prescribed for others. (Res. 910, I-12)	Retain as amended and change to an H policy.
H-100.961	The Evolving Culture of Drug Safety in the United States: Risk Evaluation and Mitigation Strategies (REMS)	Our AMA urges that: (1) The Food and Drug Administration (FDA) issue a final industry guidance on Risk Evaluation and Mitigation Strategies (REMS) with provisions that: (a) require sponsors to consult with impacted physician groups and other key stakeholders early in the process when developing REMS with elements to assure safe use (ETASU); (b) establish a process to allow for physician feedback regarding emerging issues with REMS requirements; (c) clearly specify that sponsors must assess the impact of ETASU on patient access and clinical practice, particularly in underserved areas or for patients with serious and life threatening conditions, and to make such assessments publicly available; and (d) conduct a long-term assessment of the prescribing patterns of drugs with REMS requirements.	Retain as amended to delete duplicate language.

		(2) The FDA ensure appropriate Advisory Committee review of proposed REMS with ETASU before they are finalized as part of the premarket review of New Drug Applications, and that the Drug Safety and Risk Management Advisory Committee fulfills this obligation for drugs that are already on the market and subject to REMS because of new safety information. (3) To the extent practicable, a process is established whereby the FDA and sponsors work toward standardizing procedures for certification and enrollment in REMS programs, and the common definitions and procedures for centralizing and standardizing REMS that rely on ETASU are developed. (4) REMS-related documents intended for patients (e.g., Medication Guides, acknowledgment/consent forms) be tested for comprehension and be provided at the appropriate patient literacy level in a culturally competent manner. (5) The Food and Drug Administration (FDA) issue a final industry guidance on Risk Evaluation and Mitigation Strategies (REMS) with provisions that: (a) urge sponsors to consult with impacted physician groups and other key stakeholders early in the process when developing REMS with elements to assure safe use (ETASU); (b) establish a process to allow for physician feedback regarding emerging issues with REMS requirements; and (c) recommend that sponsors assess the impact of ETASU on patient access and clinical practice, particularly in underserved areas or for patients with serious and life threatening conditions, and to make such assessments publicly available. (6) The FDA, in concert with the pharmaceutical industry, evaluate the evidence for the overall effectiveness of REMS with ETASU in promoting the safe use of medications and appropriate prescribing behavior. ~~(7) The FDA ensure appropriate Advisory Committee review of proposed REMS with ETASU before they are finalized as part of the premarket review of New Drug Applications, and that the Drug Safety and Risk Management Advisory Committee fulfills this obligation for drugs that are already on the market and subject to REMS because of new safety information.~~ ~~(8) To the extent practicable, a process is established whereby the FDA and sponsors work toward standardizing procedures for certification and enrollment in REMS programs, and the common definitions and procedures for centralizing and standardizing REMS that rely on ETASU are developed.~~ ~~(9) REMS-related documents intended for patients (e.g., Medication Guides, acknowledgment/consent~~	

		~~forms) be tested for comprehension and be provided at the appropriate patient literacy level in a culturally competent manner.~~ (~~10~~7) The FDA solicit input from the physician community before establishing any REMS programs that require prescriber training in order to ensure that such training is necessary and meaningful, requirements are streamlined and administrative burdens are reduced. (CSAPH Rep. 8, A-10; Reaffirmed: Res. 917, I-10; Appended: CSAPH Rep. 3, I-12)	
H-120.950	Change DEA Procedures in Partial Filling of Schedule II Prescriptions	Our AMA supports changes to ~~requests that~~ the federal Drug Enforcement Administration's ~~change its~~ partial filling of Schedule II Prescription regulation (21 CFR 1306.13) so that patients can acquire the balance of a prescription if, for whatever reason, only a portion of the supply was dispensed when the prescription was presented to a licensed pharmacy. (Res. 505, A-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain in part as amended. The Comprehensive Addiction and Recovery Act of 2016 created new partial dispensing exceptions which were incorporated into the DEA pharmacist's manual in 2020.
H-120.973	DEA, Diagnosis and ICD-~~9~~10-CM Codes on Prescriptions	Our AMA, in order to protect patient confidentiality and to minimize administrative burdens on physicians, opposes requirements by pharmacies, prescription services, and insurance plans to include such information as ICD-~~9~~10-CM codes and diagnoses on prescriptions. (Sub. Res. 518, A-93; Reaffirmation A-97; Reaffirmed by Sub. Res. 205, A-98; Reaffirmed: Res. 523, A-00; Amended: Res. 527, A-02; Modified: CSAPH Rep. 1, A-12)	Retain as amended with change in title.
H-135.932	Light Pollution: Adverse Health Effects of Nighttime Lighting	Our AMA: 1. Supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency. 2. Recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment. 3. Supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night. 4. That work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place. (CSAPH Rep. 4, A-12)	Retain, still relevant.

H-135.937	Advocating and Support for Light Pollution Control Efforts and Glare Reduction for Both Public Safety and Energy Savings	Our AMA: (1) will advocate that all future outdoor lighting be of energy efficient designs to reduce waste of energy and production of greenhouse gasses that result from this wasted energy use; (2) supports light pollution reduction efforts and glare reduction efforts at both the national and state levels; and (3) supports efforts to ensure all future streetlights be of a fully shielded design or similar non-glare design to improve the safety of our roadways for all, but especially vision impaired and older drivers. (Res. 516, A-09; Reaffirmed: CSAPH Rep. 4, A-12)	Retain, as amended still relevant.
H-135.959	Eliminating Lead, Mercury and Benzene from Common Household Products	Our AMA: (1) supports the development of standards to achieve non-hazardous levels of exposure to lead, mercury, or benzene arising from common household or workplace products; (2) encourages efforts to minimize or eliminate mercury use in hospitals and other health care facilities; and (3) will work in coalitions with appropriate federal agencies and health care organizations to educate physicians and other health care professionals about suitable alternatives to the use of mercury and mercury-containing devices and the appropriate disposal of mercury and mercury-containing devices; (4) encourages efforts to minimize or eliminate lead in all commercial and household products. (Sub. Res. 418, I-92; Appended: Sub. Res. 410, A-00; Reaffirmation I-00; Reaffirmed A-03; Modified: CSAPH Rep. 7, A-10; Reaffirmed in lieu of Res. 522, A-12)	Retain; still relevant.
H-140.855	Gene Patents and Accessibility of Gene Testing	Our AMA: (1) opposes patents on naturally-occurring human DNA or RNA sequences; (2) supports legislation requiring that existing gene patents be broadly licensed so as not to limit access through exclusivity terms, excessive royalties or other unreasonable terms; and (3) supports legislation that would exempt from claims of infringement those who use patented genes for medical diagnosis and research. (Res. 526, A-10; Modified in lieu of Res. 504, A-12)	Retain; still relevant.
H-150.935	Encouraging Healthy Eating Behaviors in Children Through Corporate Responsibility	Our AMA: 1) supports and encourages corporate social responsibility in the use of marketing incentives that promote healthy childhood behaviors, including the consumption of healthy food in accordance with federal guidelines and recommendations; and 2) encourages fast food restaurants to establish competitive pricing between less healthy and more healthy food choices in children's meals.	Retain; still relevant.

		(Sub. Res. 402, A-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 435, A-12)	
H-170.961	Prevention of Obesity Through Instruction in Public Schools	Our AMA will urge appropriate agencies to support legislation that would require meaningful yearly instruction in nutrition, including instruction in the causes, consequences, and prevention of obesity, in grades 1 through 12 in public schools and will encourage physicians to volunteer their time to assist with such an effort. (Res. 426, A-12)	Retain; still relevant.
H-170.999	Health Instruction and Physical Education in Schools	The AMA reaffirms its long-standing and fundamental belief that health education should be an integral and basic part of school and college curriculums, and encourages state and local medical societies to work with the appropriate health education officers and agencies in their communities to achieve this end. (BOT Res., A-60; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-07; Reaffirmed: BOT Rep. 21, A-12)	Retain; still relevant
H-245.968	Guidelines on Neonatal Resuscitation	Our AMA will support programs designed to educate health care professionals who treat premature infants, as well as parents and caregivers of premature infants, on evidence-based guidelines on neonatal resuscitation, especially with regard to premature infants born at the cusp of viability. (Sub. Res. 520, A-12)	Retain; still relevant.
H-250.988	Low Cost Drugs to ~~Poor~~ Economically Disadvantaged Countries During Times of Pandemic Health Crises	Our AMA: (1) encourages pharmaceutical companies to provide low cost medications to countries during times of pandemic health crises; and (2) shall work with the World Health Organization (WHO), UNAID, and similar organizations that provide comprehensive assistance, including health care, to ~~poor~~ economically disadvantaged countries in an effort to improve public health and national stability. (Res. 402, A-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain as amended with change in title. The term "economically disadvantaged" is preferred over "poor."
H-410.955	Physician Representation on Expert Panels	Our AMA encourages government panels and task forces dealing with specific disease entities to have representation by physicians with expertise in those diseases. (Res. 509, A-10; Reaffirmation A-12; Reaffirmed: Sub. Res. 517, A-12)	Retain; still relevant.
H-410.960	Quality Patient Care Measures	Our AMA encourages all physicians to be open to the development and broader utilization of evidence-based quality improvement guidelines (pathways, parameters) and indicators for measurement of quality practice. (Res. 811, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain; still relevant.

H-410.967	~~Guide to~~ Clinical Preventive Services	The AMA: (1) recommends the USPSTF guidelines ~~Guide to Clinical Preventive Services~~ to clinicians and medical educators as one resource for guiding the delivery of clinical preventive services. USPSTF recommendations ~~The Guide~~ should not be construed as AMA policy on screening procedures and should not take the place of clinical judgment and the need for individualizing care with patients; physicians should weigh the utility of individual recommendations within the context of their scope of practice and the situation presented by each clinical encounter; (2) will continue to encourage the adoption of practice guidelines as they are developed based on the best scientific evidence and methodology available; and (3) will continue to promote discussion, collaboration, and consensus among expert groups and medical specialty societies involved in preparation of practice guidelines. (CSA Rep. 1, A-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Sub. Res. 517, A-12)	Retain as amended with change in title. The terminology "Guide to Clinical Preventive Services" is no longer utilized.
H-420.960	Effects of Work on Pregnancy	Our AMA: (1) supports the right of employees to work in safe workplaces that do not endanger their reproductive health or that of their unborn children; (2) supports workplace policies that minimize the risk of excessive exposure to toxins with known reproductive hazards irrespective of gender or age; (3) encourages physicians to consider the potential benefits and risks of occupational activities and exposures on an individual basis and work with patients and employers to define a healthy working environment for pregnant people ~~women~~; (4) encourages employers to accommodate ~~women's~~ increased physical requirements of pregnant people~~during pregnancy~~; recommended accommodations include varied work positions, adequate rest and meal breaks, access to regular hydration, and minimizing heavy lifting; and (5) acknowledges that future research done by interdisciplinary study groups composed of obstetricians/gynecologists, occupational medicine specialists, pediatricians, and representatives from industry can best identify adverse reproductive exposures and appropriate accommodations. (CSA Rep. 9, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-12)	Retain as amended to include gender-neutral language.
H-430.994	Prison-Based Treatment Programs for Drug Abuse	Our AMA: (1) encourages the increased application to the prison setting of the principles, precepts and processes derived from drug-free residential therapeutic community experience; and (2) urges state health departments or other appropriate agencies to take the lead in working	Rescind. Outdated policy. See Policy H-430.987, "Medications for

		with correction and substance abuse agencies for the expansion of such prison-based drug-free treatment programs. (Sub. Res. 124, I-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmation: I-12)	Opioid Use Disorder in Correctional Facilities"
H-430.997	Standards of Care for Inmates of Correctional Facilities	Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder ~~misuse~~ care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism. (Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12)	Retain as amended to reflect clinically accurate language.
H-440.844	Expansion of National Diabetes Prevention Program	Our AMA: (1) supports evidence-based, physician-prescribed diabetes prevention programs, (2) supports the expansion of the NDPP to more CDC-certified sites across the country; and (3) will support coverage of the NDPP by Medicare and all private insurers. (Sub. Res. 911, I-12)	Retain; still relevant.
H-440.848	Reimbursement for Influenza Vaccine	Our AMA: (1) will work with third party payers, including the Centers for Medicare and Medicaid Services, to establish a fair reimbursement price for the flu vaccine; (2) encourage the manufacturers of influenza vaccine to publish the purchase price by June 1st each year; (3) shall seek federal legislation or regulatory relief, or otherwise work with the federal government to increase Medicare reimbursement levels for flu vaccination and other vaccinations. (CSAPH Rep. 5, I-12)	Retain; still relevant.
H-440.849	Adult Immunization	Our AMA (1) supports the development of a strong adult and adolescent immunization program in the United States; (2) encourages physicians and other health and medical workers (in practice and in training) to set positive examples by assuring that they are completely immunized; (3) urges physicians to advocate immunization with all adult patients to whom they provide care, to provide indicated vaccines to ambulatory as well as hospitalized patients, and to maintain complete immunization records, providing copies to patients as necessary; (4) encourages the National Adult and Influenza ~~Vaccine~~ Immunization Summit to examine mechanisms to ensure that patient immunizations get communicated to their personal physician; (5) promotes use of available public and professional educational materials to increase use	Retain as amended to reflect the appropriate name of the Summit.

		of vaccines and toxoids by physicians and to increase requests for and acceptance of these antigens by adults for whom they are indicated; and (6) encourages third party payers to provide coverage for adult immunizations. (CSAPH Rep. 5, I-12)	
H-440.852	Smallpox: A Scientific Update	Our AMA will remain engaged with the CDC, the Advisory Committee on Immunization Practices (ACIP), and the Federation on smallpox vaccination and support a commitment to monitor the current status of smallpox and smallpox vaccination in the world and in the United States and develop appropriate recommendations as necessary. (CSA Rep. 2, I-02; BOT Action in response to referred for decision Recommendation 2 of CSA Rep. 2, I-02; Modified: CCB/CLRPD Rep. 4, A-12)	Retain; still relevant.
H-440.872	HPV Vaccine and Cervical Cancer Prevention Worldwide	1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs. 2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public. 3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination. (Res. 503, A-07; Appended: Res. 6, A-12)	Retain; still relevant.
H-440.889	Smallpox: A Scientific Update	Our AMA strongly supports the ~~June 20, 2002~~, Advisory Committee on Immunization Practices (ACIP) recommendations on the use of vaccinia (smallpox) vaccine in light of the available science and data. (CSA Rep. 2, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain with amendments; ACIP recommendations have been updated.

H-440.921	Pneumococcal Vaccination	Our AMA encourages physicians to expand their use of pneumococcal vaccine per current Advisory Committee on Immunization Practices recommendations~~, for those at increased risk of serious pneumococcal infection and for all persons age 65 and over~~. (Res. 512, A-94; Reaffirmed: Res. 515. I-01; Reaffirmed: Res. 520, A-02; Modified: CSAPH Rep. 1, A-12)	Retain with amendment should ACIP recommendations evolve based on the evidence.
H-445.995	Responses to News Reports and Articles	Our AMA encourages the public relations committees of all county, state and national medical societies to initiate positive programs with the media and to make timely responses to misleading and inaccurate media releases giving the general public a more accurate and balanced perspective of the medical profession and medical issues. (Res. 10, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-07; Reaffirmed: Res. 601, A-12)	Retain; still relevant.
H-460.905	Clinical Application of Next Generation Genomic Sequencing	1. Our AMA recognizes the utility of next-generation sequencing (NGS)-based technologies as tools to assist in diagnosis, prognosis, and management, and acknowledges their potential to improve health outcomes. 2. Our AMA encourages the development of standards for appropriate clinical use of NGS-based technologies and best practices for laboratories performing such tests. 3. Our AMA will monitor research on and implementation of NGS-based technologies in clinical care, and will work to inform and educate physicians and physicians-in-training on the clinical uses of such technologies. 4. Our AMA will support regulatory policy that protects patient rights and confidentiality, and enables physicians to access and use diagnostic tools, such as NGS-based technologies, that they believe are clinically appropriate. 5. Our AMA will continue to enhance its process for development of CPT codes for evolving molecular diagnostic services, such as those that are based on NGS; serve as a convener of stakeholders; and maintain its transparent, independent, and evidence-based process. (CSAPH Rep. 4, I-12)	Retain; still relevant.
H-470.975	Mandatory Physical Education	The AMA continues its commitment to support state and local efforts to implement quality physical education programs for all students, including those with physical, developmental, or intellectual challenges or other special needs in grades kindergarten through twelve, including ungraded classes.	Retain; still relevant.

		(Sub. Res. 1, I-88; Reaffirmation and Sunset Report, I-98; Reaffirmation A-07; Modified: BOT Rep. 21, A-12)	
H-470.989	Physical Fitness and Physical Education	Our AMA: (1) urges school boards, administrators and parents to provide physical education programs during elementary, junior high and senior high years; and (2) stresses that these programs be conducted by qualified personnel, be designed to teach health habits and physical skills, and be designed to instill a desire in the student for physical fitness that will carry over into adult life. (CSA Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmation I-98; Reaffirmation A-04; Reaffirmation A-07; Reaffirmed: BOT Rep. 21, A-12)	Retain; still relevant
H-470.990	Promotion of Exercise Within Medicine and Society	Our AMA supports (1) education of the profession on exercise, including instruction on the role of exercise prescription in medical practice in its continuing education courses and conferences, whenever feasible and appropriate; (2) medical student instruction on the prescription of exercise; (3) physical education instruction in the school system; and (4) education of the public on the benefits of exercise, through its public relations program. (Res. 56, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation I-98; Reaffirmation A-07; Reaffirmed: BOT Rep. 21, A-12)	Retain; still relevant
H-470.996	School and College Physical Education	Our AMA encourages effective instruction in physical education for all students in our schools and colleges. (BOT Rep. I, A-69; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation I-98; Reaffirmation A-07; Reaffirmed: BOT Rep. 21, A-12)	Retain; still relevant
H-480.958	Bioengineered (Genetically Engineered) Crops and Foods	(1) Our AMA recognizes the continuing validity of the three major conclusions contained in the ~~1987~~ National Academy of Sciences white paper "Introduction of Recombinant DNA-Engineered Organisms into the Environment." [The three major conclusions are: (a)There is no evidence that unique hazards exist either in the use of rDNA techniques or in the movement of genes between unrelated organisms; (b) The risks associated with the introduction of rDNA-engineered organisms are the same in kind as those associated with the introduction of unmodified organisms and organisms modified by other methods; (c) Assessment of the risk of introducing rDNA-engineered organisms into the environment should be based on the nature of the organism and the environment into which it is introduced, not on the method by which it was produced.)	Retain; still relevant with acknowledgment by the Council that an updated report to review more recent data is warranted.

		(2) That federal regulatory oversight of agricultural biotechnology should continue to be science-based and guided by the characteristics of the plant or animal, its intended use, and the environment into which it is to be introduced, not by the method used to produce it, in order to facilitate comprehensive, efficient regulatory review of new bioengineered crops and foods. (3) Our AMA believes that ~~as of June 2012,~~ there is no scientific justification for special labeling of bioengineered foods, as a class, and that voluntary labeling is without value unless it is accompanied by focused consumer education. (4) Our AMA supports mandatory pre-market systematic safety assessments of bioengineered foods and encourages: (a) development and validation of additional techniques for the detection and/or assessment of unintended effects; (b) continued use of methods to detect substantive changes in nutrient or toxicant levels in bioengineered foods as part of a substantial equivalence evaluation; (c) development and use of alternative transformation technologies to avoid utilization of antibiotic resistance markers that code for clinically relevant antibiotics, where feasible; and (d) that priority should be given to basic research in food allergenicity to support the development of improved methods for identifying potential allergens. The FDA is urged to remain alert to new data on the health consequences of bioengineered foods and update its regulatory policies accordingly. (5) Our AMA supports continued research into the potential consequences to the environment of bioengineered crops including the: (a) assessment of the impacts of pest-protected crops on nontarget organisms compared to impacts of standard agricultural methods, through rigorous field evaluations; (b) assessment of gene flow and its potential consequences including key factors that regulate weed populations; rates at which pest resistance genes from the crop would be likely to spread among weed and wild populations; and the impact of novel resistance traits on weed abundance; (c) implementation of resistance management practices and continued monitoring of their effectiveness; (d) development of monitoring programs to assess ecological impacts of pest-protected crops that may not be apparent from the results of field tests; and (e) assessment of the agricultural impact of bioengineered foods, including the impact on farmers. (6) Our AMA recognizes the many potential benefits offered by bioengineered crops and foods, does not support a moratorium on planting bioengineered crops, and encourages ongoing	

		research developments in food biotechnology. (7) Our AMA urges government, industry, consumer advocacy groups, and the scientific and medical communities to educate the public and improve the availability of unbiased information and research activities on bioengineered foods. (CSA Rep. 10, I-00; Modified: CSAPH Rep. 1, A-10; Modified: C~~AS~~SAPH Rep. 2, A-12)	
H-480.964	Alternative Medicine	Policy of the AMA on alternative medicine is: (1) Well-designed, controlled research should be done to evaluate the efficacy of alternative therapies. (2) Physicians should routinely inquire about the use of alternative or unconventional therapy by their patients, and educate themselves and their patients about the state of scientific knowledge with regard to alternative therapy that may be used or contemplated. (3) Patients who choose alternative therapies should be educated as to the hazards that might result from postponing or stopping conventional medical treatment. (CSA Rep. 12, A-97; Reaffirmed: BOT Rep. 36, A-02; Modified: CSAPH Rep. 1, A-12)	Retain; still relevant.
H-485.998	Television Commercials Aimed at Childre	Our AMA opposes TV advertising and programming aimed specifically at exploiting children, particularly those ads and programs that have an impact on the health and safety of children. (Res. 27, A-79; Reaffirmed: CLRPD Rep. B, I-89; Sub. Res. 220, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmation A-12)	Retain; still relevant.
H-495.974	Tax Incentives and Films Depicting Tobacco	Our AMA will urge that no tax incentives be given for any motion picture production that depicts any tobacco product or non-pharmaceutical nicotine delivery device or its use, associated paraphernalia, related trademarks or promotional material, unless the film depicts the tobacco use of historical persons or unambiguously portrays the dire health consequences of tobacco use. (Res. 417, A-12)	Retain; still relevant.
H-495.981	Light and Low-Tar Cigarettes	Our AMA concurs with the key scientific findings of National Cancer Institute Monograph 13, Risks Associated with Smoking Cigarettes with Low Machine-Measured Yields of Tar and Nicotine: (a) Epidemiological and other scientific evidence, including patterns of mortality from smoking-caused diseases, does not indicate a benefit to public health from changes in cigarette design and manufacturing over the last 50 years. (b) For spontaneous brand switchers, there appears to be complete compensation for nicotine delivery, reflecting more intensive smoking of lower-yield cigarettes. (c) Cigarettes with low machine-	Retain; still relevant.

		measured yields by Federal Trade Commission (FTC) methods are designed to allow compensatory smoking behaviors that enable a smoker to derive a wide range of tar and nicotine yields from the same brand. (d) Widespread adoption of lower yield cigarettes in the United States has not prevented the sustained increase in lung cancer among older smokers. (e) Many smokers switch to lower yield cigarettes out of concern for their health, believing these cigarettes to be less risky or to be a step toward quitting; many smokers switch to these products as an alternative to quitting. (f) Advertising and promotion of low tar cigarettes were intended to reassure smokers who were worried about the health risks of smoking, were meant to prevent smokers from quitting based on those same concerns; such advertising was successful in getting smokers to use low-yield brands. (g) Existing disease risk data do not support making a recommendation that smokers switch cigarette brands. The recommendation that individuals who cannot stop smoking should switch to low yield cigarettes can cause harm if it misleads smokers to postpone serious attempts at cessation. (h) Measurements of tar and nicotine yields using the FTC method do not offer smokers meaningful information on the amount of tar and nicotine they will receive from a cigarette. Our AMA seeks legislation or regulation to prohibit cigarette manufacturers from using deceptive terms such as "light," "ultra-light," "mild," and "low-tar" to describe their products. (CSA Rep. 3, A-04; Reaffirmed in lieu of Res. 421, A-12)	
H-515.959	Reduction of Online Bullying	Our AMA urges social networking platforms to adopt Terms of Service that define and prohibit electronic aggression, which may include any type of harassment or bullying, including but not limited to that occurring through e-mail, chat room, instant messaging, website (including blogs) or text messaging. (Res. 401, A-12)	Retain; still relevant
H-525.984	Breast Implants	Our AMA: (1) supports that individuals ~~women~~ be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose; and (2) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated.	Retain as amended; to include gender-neutral language.

		(CSA Rep. M, I-91; Modified: Sunset Report, I-01; Reaffirmed: Res. 727, I-02; Modified: CSAPH Rep. 1, A-12)	
H-55.974	Study of Cancer Incidence in 9/ll Responders	Our AMA will encourage further study of the association between post-September 11, 2001 World Trade Center attack exposure and cancer incidence. (Res. 501, A-12)	Retain; still relevant.
H-60.927	Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations	Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth. (Res. 402, A-12)	Retain; still relevant
H-60.943	Bullying Behaviors Among Children and Adolescents	Our AMA: (1) recognizes bullying as a complex and abusive behavior with potentially serious social and mental health consequences for children and adolescents. Bullying is defined as a pattern of repeated aggression; with deliberate intent to harm or disturb a victim despite apparent victim distress; and a real or perceived imbalance of power (e.g., due to age, strength, size), with the more powerful child or group attacking a physically or psychologically vulnerable victim; (2) advocates for federal support of research: (a) for the development and effectiveness testing of programs to prevent or reduce bullying behaviors, which should include rigorous program evaluation to determine long-term outcomes; (b) for the development of effective clinical tools and protocols for the identification, treatment, and referral of children and adolescents at risk for and traumatized by bullying; (c) to further elucidate biological, familial, and environmental underpinnings of aggressive and violent behaviors and the effects of such behaviors; and (d) to study the development of social and emotional competency and resiliency, and other factors that mitigate against violence and aggression in children and adolescents; (3) urges physicians to (a) be vigilant for signs and symptoms of bullying and other psychosocial trauma and distress in children and adolescents; (b) enhance their awareness of the social and mental health consequences of bullying and other aggressive behaviors; (c) screen for psychiatric comorbidities in at-risk patients; (d) counsel affected patients and their families on effective intervention programs and coping strategies; and (e) advocate for family, school, and community	Retain; still relevant

		programs and services for victims and perpetrators of bullying and other forms of violence and aggression; (4) advocates for federal, state, and local resources to increase the capacity of schools to provide safe and effective educational programs by which students can learn to reduce and prevent violence. This includes: (a) programs to teach, as early as possible, respect and tolerance, sensitivity to diversity, and interpersonal problem-solving; (b) violence reduction curricula as part of education and training for teachers, administrators, school staff, and students; (c) age and developmentally appropriate educational materials about the effects of violence and aggression; (d) proactive steps and policies to eliminate bullying and other aggressive behaviors; and (e) parental involvement; (5) advocates for expanded funding of comprehensive school-based programs to provide assessment, consultation, and intervention services for bullies and victimized students, as well as provide assistance to school staff, parents, and others with the development of programs and strategies to reduce bullying and other aggressive behaviors; and (6) urges parents and other caretakers of children and adolescents to: (a) be actively involved in their child's school and community activities; (b) teach children how to interact socially, resolve conflicts, deal with frustration, and cope with anger and stress; and (c) build supportive home environments that demonstrate respect, tolerance, and caring and that do not tolerate bullying, harassment, intimidation, social isolation, and exclusion. (CSA Rep. 1, A-02; Reaffirmed: CSAPH Rep. 1, A-12)	
H-60.991	Providing Medical Services through School-Based Health Programs	(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school	Retain; still relevant.

		and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children. (CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12)	
H-65.973	Health Care Disparities in Same-Sex Partner Households	Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households. (CSAPH Rep. 1, I-09; BOT Action in response to referred for decision Res. 918, I-09: Reaffirmed in lieu of Res. 918, I-09; BOT Rep. 15, A-11; Reaffirmed in lieu of Res. 209, A-12)	Retain; still relevant.
H-85.961	Accuracy, Importance, and Application of	Our AMA encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the mother and	Retain; still relevant.

	Data from the US Vital Statistics System	infant, as this information is the basis for the health and medical information on birth certificates. (CSA Rep. 6, I-00; Reaffirmed: Sub. Res. 419, A-02; Modified: CSAPH Rep. 1, A-12)	

REPORT 02 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-22)
Transformation of Rural Community Public Health Systems
(Reference Committee D)

EXECUTIVE SUMMARY

BACKGROUND. More than 65 million people living in the United States reside in rural jurisdictions. Rural populations tend to be older, poorer, have less access to health care, have riskier health behaviors, and worse health outcomes than their urban counterparts. Data from the Centers for Disease Control and Prevention (CDC) demonstrates that people living in rural areas are more likely to die from five leading causes of death (heart disease, cancer, unintentional injuries, chronic lower respiratory disease, and stroke) than their urban counterparts. However, the challenges faced by rural areas are not uniform as they have their own unique cultural and geographic differences that benefit from leadership at the local level.

METHODS. English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from January 2012 to January 2022 using the search terms: "rural public health," "rural community health," and "rural health. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies, applicable professional organizations, and foundations were also reviewed for relevant information.

DISCUSSION. There are more than 2400 local health departments (LHDs) in the United States. It is estimated that about half of LHDs are rural and they differ from their urban and suburban counterparts. Rural LHDs are often limited by budgets, staffing, and capacity constraints in providing public health services, thereby limiting their ability to respond to national public health and health care policy initiatives. With less funding and fewer staff, rural LHDs are often not able to meet the needs of a sicker population over a larger geographical area. It should be noted that some rural areas are not served by a LHD, but rather by a regional or state health department (e.g., Rhode Island). The lack of health care available in rural jurisdictions also contributes in part to the lack of essential and foundational public health services provided in rural communities with rural health departments often left to fill the gap in the absence of other sources of health care.

CONCLUSIONS. Ultimately, residents in rural communities should have equitable access to the essential and foundational public health services provided by the public health system in other jurisdictions. To achieve this, research is needed to determine the needs and models for delivering public health services in rural communities as well as best practices for addressing health behaviors and the social determinants of health in these communities. While examples of using telehealth during the COVID-19 pandemic and cross jurisdictional sharing are helpful, there is little in the published literature regarding successful models for increasing population level public health activities in rural communities. This is likely in part due to rural health departments having little capacity and funding to participate in research and publish results.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-A-22

Subject: Transformation of Rural Community Public Health Systems

Presented by: Alexander Ding, MD, MS, MBA, Chair

Referred to: Reference Committee D

INTRODUCTION

Policy H-465.994, "Improving Rural Health," asks that our American Medical Association study efforts to optimize rural public health.

BACKGROUND

More than 65 million people living in the United States reside in rural jurisdictions.[1] Rural populations tend to be older, poorer, have less access to health care, have riskier health behaviors, and worse health outcomes than their urban counterparts.[2,3] Data from the Centers for Disease Control and Prevention (CDC) demonstrate that people living in rural areas are more likely to die from five leading causes of death (heart disease, cancer, unintentional injuries, chronic lower respiratory disease, and stroke) than their urban counterparts.[3] However, the challenges faced by rural areas are not uniform as they have their own unique cultural and geographic differences that benefit from leadership at the local level.

The Council's N-21 report, "Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems," is highly relevant to this report. That report identified eight major gaps or challenges in the U.S. public health infrastructure. While those challenges were not specific to rural public health, they are broadly applicable across the governmental public health enterprise. These include: (1) the lack of understanding and appreciation for public health; (2) the lack of consistent, sustainable public health funding; (3) legal authority and politicization of public health; (4) the governmental public health workforce; (5) the lack of data and surveillance and interoperability between health care and public health; (6) insufficient laboratory capacity; (7) the lack of collaboration between medicine and public health; and (8) the gaps in the public health infrastructure which contribute to the increasing inequities we see in health outcomes. This report recognizes that these challenges are applicable to rural public health, but this report seeks to build on those findings to examine the challenges and opportunities specific to rural public health.

Furthermore, issues related to rural health care have recently been studied by other AMA councils and will not be the focus of this report. Report 3 of the Council on Medical Education, "Rural Health Physician Workforce Disparities" was adopted as amended by the House of Delegates in November of 2021. The report recognized the need for a multifaceted approach to address the gap of rural health services and noted that the AMA continues to work to help identify ways to encourage and incentivize qualified physicians to practice in our nation's underserved areas, including strategies to increase rural students' exposure to careers in medicine to help expand rural physician pathways. Report 9 of the Council on Medical Services, "Addressing Payment and Delivery in Rural Hospitals" was adopted as amended by the House of Delegates in June of 2021.

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The report notes that addressing payment issues for rural hospitals will help give those hospitals the flexibility to offer more complex services. In turn, those services will boost financial viability, allow small rural hospitals to hire and retain subspecialists, and ultimately increase patient access to care. Policies resulting from these reports are noted below in the section on existing AMA policy.

There are numerous definitions of "rural." The definition of rural public health practice varies by study. Given the limited research available on rural public health, the Council was broadly inclusive of various definitions of rural, including the Census Bureau and the Office of Management and Budget definitions, in reviewing the literature for this report.

METHODS

English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from January 2012 to January 2022 using the search terms: "rural public health," "rural community health," and "rural health." Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal agencies, applicable professional organizations, and foundations were also reviewed for relevant information.

DISCUSSION

Rural-Urban Disparities

Residents of rural communities tend to be sicker, poorer, and have worse health behaviors (e.g., higher alcohol and tobacco use, physical inactivity) than their urban peers. According to the Center for Rural Health Research, "the greatest challenge facing rural America is the confluence of four social vectors: poverty, educational underachievement, poor health behaviors, and lack of access to health care."[4] These four factors have produced "an intergenerational cycle" resulting in widening gaps between rural America and the rest of the country.[4]

While urban public health systems have enhanced their scope of activities and organizational networks since 2014, rural systems have lost capacity, suggesting system improvement initiatives have had uneven success.[5] While urban areas have seen significant improvements in some health indicators, rural areas continue to lag, widening rural-urban health disparities. For example, from 2007 to 2017, rural-urban mortality disparities increased for 5 of 7 major causes of death tracked by Healthy People 2020: coronary heart disease, cancer, diabetes, chronic obstructive pulmonary disease, and suicide.[6]

These disparities have also been evident during the COVID-19 pandemic. In September 2020, COVID-19 incidence (cases per 100,000 population) in rural counties surpassed that in urban counties.[7] When the CDC analyzed county-level vaccine administration data among adults aged 18 and older who received their first dose of either the Pfizer-BioNTech or Moderna COVID-19 vaccine, or a single dose of the Janssen COVID-19 vaccine from December 14, 2020–April 10, 2021. They found that adult COVID-19 vaccination coverage was lower in rural counties (38.9 percent) than in urban counties (45.7 percent) overall.[7] Though it is suggested that implementing approaches tailored to local community needs, partnering with local community-based organizations and faith leaders, and engaging with underserved populations directly and through partners has helped increase vaccination rates in some rural communities.[7]

In describing disparities between rural and urban communities, there is a focus on the lack of resources and resulting impact on health of those living in rural communities, but it is important to highlight that the lack of resources has stimulated creativity and often brings people together across sectors in rural communities to solve the problems facing their population.[8] Researchers working in rural communities describe "cross-sector engagement facilitated by strong social cohesion and a willingness to roll up one's sleeves to address challenges head on."[8] This "strong connectivity across sectors and actors" in rural areas, has resulted in organizations forming partnerships to address issues related to the economy, nutrition, health care, business, and education.[9] Research also suggests that rural communities are resilient, defined as "the ability to prepare and plan for, absorb, recover from or more successfully adapt to actual or potential adverse events." This resilience enables rural communities to respond to economic and social changes.[9] Rural communities are also described as having "pride in place, a shared history, and a shared culture.[8]

Access to Health Care

Access to health care in rural jurisdictions impacts the ability of the public health systems to focus on essential public health services and functions. Nearly 35 years ago, the Institute of Medicine's report on the "Future of Public Health" noted that the responsibility for providing medical care to individuals has drained vital resources and attention away from disease prevention and health promotion efforts that benefit the entire community.[10] While many health departments have moved away from providing clinical services, local health departments (LHDs) in rural areas are often left to fill the gaps in the absence of health care providers. If LHDs in these jurisdictions did stop providing clinical services, they would not be available for the general population. Rural LHDs play a critical role in meeting the needs of the residents by providing clinical preventive services, vaccinations, treatment, and maternal and child health services.[11] Rural LHDs also rely more on clinical services because they receive a higher proportion of revenue from clinical sources than their urban counterparts.[12]

HEALTH DEPARTMENT STRUCTURE AND FUNCTIONS

There are more than 2400 local health departments (LHDs) in the United States. It is estimated that about half of LHDs are rural and they differ from their urban and suburban counterparts.[1] Rural LHDs, similar to their urban counterparts, are often limited by budgets, staffing, and capacity constraints in providing public health services, thereby limiting their ability to respond to national public health and health care policy initiatives.[13] With less funding and fewer staff, rural LHDs are often not able to meet the needs of a sicker population over a larger geographical area.[14] It should be noted that some rural areas are not served by a LHD, but rather by a regional or state health department (e.g. Rhode Island).

Leadership and Workforce

Effective public health practice requires a well-prepared, multi-disciplinary workforce that is equipped to meet the needs of the community being served.[15] The Public Health Accreditation Board standards call for the development of a "sufficient number of qualified public health workers" and a competent workforce through assessment of staff competencies, individual training and professional development, and a supportive work environment. Building a strong public health workforce pipeline was also identified as a need in Public Health 3.0 with a focus on leadership and management skills in systems thinking and coalition building [16]

More than 80 percent of LHD full-time employees (FTEs) (112,000) are employed in departments serving urban areas. Only 18 percent of LHD FTEs (24,000) are employed by LHDs that serve

rural populations.[17] Small, rural LHDs often have fewer staff than their urban counterparts.[1] Nurses are often the executive in jurisdictions with a population less than 50,000, while executives of jurisdictions with more than 250,000 are predominantly physicians.[18] Overall, small/rural health departments employ fewer FTEs than do large/urban departments, resulting in a narrower range of public health skills. Seventy-eight percent of LHD executives have no formal public health training, while executives of larger jurisdictions are more likely to have a public health degree.[18]

The other challenge facing the public health workforce more broadly is a significant number of governmental public health workers are planning to leave their position. Data form the Public Health Workforce Interests and Needs Survey found that more than one-fifth of LHD staff intended to leave their position in the next year for reasons other than retirement.[19] Salary, lack of opportunity for advancement, and workplace environment were the top three reasons for leaving.[19]

Funding Sources

The governmental public health system is inadequately funded. The CDC's core budget has been essentially flat, which directly impacts funding for state and local public health across the country.[20] Rural LHDs are more reliant on federal, state, and clinical revenues as compared to their urban counterparts.[1,17] The predictability and stability of public health financing poses a challenge for rural LHDs.[2] Operating on grant dollars can make it difficult to be responsive to community needs and to create new FTEs at the local level. Furthermore, transfers of governmental funding from federal and state levels to rural LHDs is less common as compared to urban LHDs.[1] Local funding for public health is also often based on the tax base, which is low and declining in many rural areas making local investments in public health difficult.[21] Without meaningful growth in the resources available, it is challenging for local governments to meaningfully invest in public programs.[1]

As noted above, the difference in clinical revenues among rural and urban LHDs is notable, with a mean of $21 per capita for rural jurisdictions versus $6 per capita for urban jurisdictions.[17] LHDs experienced decreases in clinical revenue between 2010 and 2016.[2] Urban LHDs provided fewer primary care services in 2016; rural LHDs provided more mental health and substance use disorder services.[2] Overall, rural LHDs generate more revenue from the Centers for Medicare and Medicaid Services and clinical services than their urban counterparts.[2]

Access to Data

Limited availability or access to data, data quality issues, and limited staff with expertise in informatics and data analysis can also contribute to disparities between rural and urban LHDs. One of the biggest data challenges facing rural areas relates to privacy and confidentiality. While some data sets are publicly available for a large urban area, they may not be publicly available for rural areas due to the small size of the population and the possibility that an individual would be identifiable based on their condition or other demographic data. Outdated data sets or the lack of real-time data also makes it challenging to understand important local issues and made timely decisions.

Public Health Programs and Services

The 10 Essential Public Health Services (EPHS) provide a framework for public health to protect and promote the health of all people in all communities.[22] The Foundational Public Health Services (FPHS) framework is thought of as the minimum level of programs and services that governmental public health should be delivering in every jurisdiction. The FPHS framework allows for the

identification of capacity and resource gaps; determination of the cost for assuring foundational activities; and justification of funding needs.[23] However, it is also recognized that to best serve their communities, LHDs may provide additional services and require capacity in different areas.[23]

Maintaining the capacity to provide the nationally recommended public health services in rural areas can be challenging. Public health accreditation, which incorporates the EPHS and FPHS frameworks within its standards, is seen as an important step to improve the quality and effectiveness of public health services, but a shortage of funds, lack of staff, and insufficient staff knowledge are major barriers for rural LHDs to achieve accreditation. The programs and services provided by rural health departments differ from their urban peers. According to the National Association of City and County Health Officials (NACCHO) Profile Survey, LHDs serving rural jurisdictions are more likely to provide certain clinical services, including childhood and adult immunizations, maternal and child health services, and screening/treatment for various conditions.[17] The result is inequities in public health services across jurisdictions.

Rural Public Health Networks

Unlike urban health departments, which are represented through the Big Cities Health Coalition, there is no national group to which rural public health agencies belong and work collaboratively to advocate on behalf of rural public health and build relationships among staff.[1] The lack of rural public health-focused advocacy has resulted in a lack of focus on rural population health. National public health advocacy organizations typically do not focus on population health needs among rural populations, and national rural advocacy organizations have largely focused narrowly on health care access. While there has been some focus on rural public health challenges, it tends to be issue-specific, such as with the opioid epidemc.[1]

Similarly, while there are federal agencies focused on rural health care, the focus on rural public health is minimal. For example, the CDC does not have a centralized rural office. Rather, the Office of the Associate Director for Policy and Strategy coordinates policy and programmatic efforts across the agency on issues relevant to rural health.[24] In March of 2022, Congress approved a revised version of the Consolidated Appropriations Act (H.R. 2417), which provides funding for the remainder of FY22 and averted a government shutdown. The bill requests the CDC to assess and submit a report within 180 days of enactment of the bill on the agency's rural-focused efforts and strengthening such efforts.

RURAL PUBLIC HEALTH OPPORTUNITIES

Cross Jurisdictional Sharing

Cross-jurisdictional sharing (CJS) is a growing strategy used by health departments to address opportunities and challenges such as tight budgets, increased burden of disease, and regional planning needs.[25] By pooling resources, sharing staff, expertise, funds and programs across jurisdictions, health departments can accomplish more than they could alone.[26] CJS can range from as needed assistance such as sharing information or equipment to regionalization/consolidation, such as merging existing LHDs.[26] The Center for Sharing Public Health Services has outlined success factors, facilitating factors, and project characteristics (i.e. senior level support, effective communication) that can increase the likelihood of successful CJS.[27]

One example of successful CJS arrangements include is two rural upstate New York counties that were struggling to provide public health leadership and services forming a relationship that integrated select functions and services, including the sharing of a director and deputy director,

while maintaining two distinct LHDs.[28] The counties also contract together for medical and environmental engineering consulting, share an early childhood transportation provider, and share additional purchasing in some programs.[28] By sharing personnel and functions, management personnel costs have been cut in half and both counties have saved over $1 million for the counties combined.[28] Challenges have included anxiety among existing staffers who were concerned that their positions may be cut if tasks become shared or integrated. In New York, state legislation also limits how far integration can go, which has limited some efficiencies.[28]

Telehealth

Small, rural health departments have limited access to technology and to information that is available primarily electronically. The inability to provide in-person services because of the COVID-19 pandemic has forced rural LHDs to evaluate different modalities for providing public health services.[14] During the pandemic, rural LHDs used online meeting platforms to provide smoking cessation, diabetes self-management, and other health education classes to multiple counties. This provided a broader population with access to public health services. Telehealth can also help mitigate the lack of transportation, which is a known barrier to care.[14] Anecdotal evidence suggests that technology has allowed LHDs to maintain and expand the reach and scope of the services they provide.[14] While the use of telehealth to improve access to public health services is promising, and could improve health equity, many rural areas still lack high-speed broadband.[29]

Partnerships

Models that stress collaboration among rural LHDs and community partners hold promise for meeting the challenges of rural public health. Building partnerships among LHDs, community health centers, healthcare organizations, academic medical centers, offices of rural health, hospitals, non-profit organizations, and the private sector is essential to meet the needs of these communities.[30] NACCHO has created a guide to share recommendations and stories from the field about developing and maintaining partnerships in rural communities.[30]

EXISTING AMA POLICY

The AMA has extensive policy addressing rural health and access to health care. Policies addressing rural public health are limited to Policy H-465.994, “Improving Rural Health,” which states that the AMA will “work with other organizations interested in public health to identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health; develop an advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.”

AMA Policy H-465.994, “Improving Rural Health,” also urges physicians practicing in rural areas to be actively involved in efforts to develop and implement proposals for improving rural health care. Policy H-465.997, “Access to and Quality of Rural Health Care,” states that the AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. The AMA also supports efforts to place National Health Service Corps physicians in underserved areas of the country.

AMA Policy H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage" calls on the AMA to encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations and develop educational strategies for alleviating rural physician shortages. Policy D-465.997, "Rural Health Physician Workforce Disparities," calls on the AMA to monitor the status and outcomes of the 2020 Census to assess the impact of physician supply and patient demand in rural communities."

AMA Policy, D-465.998. "Addressing Payment and Delivery in Rural Hospitals" calls on the AMA to advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate: create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume; provide adequate service-based payments to cover the costs of services delivered in small communities; adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner; use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability; hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability; and create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone. The AMA also encourages transparency among rural hospitals regarding their costs and quality outcomes, supports better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital, and encourages employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians.

CONCLUSIONS

With an overall sicker population and larger geographical area to cover, rural LHDs are challenged to meet the needs of their population with less funding and fewer, well-trained staff. Ultimately, residents in rural communities should have equitable access to the essential and foundational public health services provided by the public health system in other jurisdictions.[12] To achieve this, research is needed to determine the needs and models for delivering public health services in rural communities as well as best practices for addressing health behaviors and the social determinants of health in these communities.[12]

While examples of using telehealth during the COVID-19 pandemic and CSJ are helpful, there's little in the published literature regarding successful models for increasing population level public health activities in rural communities. This is likely in part due to rural LHDs having little capacity and funding to participate in research and publish results. Unlike their urban counterparts, rural LHDs also lack a specific advocacy organization.

The lack of health care available in rural jurisdictions also contributes in part to the lack of essential and foundational public health services provided in rural communities, with rural LHDs often left to fill the gap in the absence of other sources of health care. While not directly the focus of this report, the AMA has extensive policy addressing access to rural health care.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1. That our AMA amend Policy H-465.994, "Improving Rural Health," by addition and deletion to read as follows:

   1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.

   2. Our AMA will work with other entities and organizations interested in public health to:
   - Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
   - Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
   - Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
   - Advocate for adequate and sustained funding for public health staffing and programs.
   - ~~Study efforts to optimize rural public health.~~

2. That our AMA amend Policy D-440.924, "Universal Access for Essential Public Health Services" by addition and deletion to read as follows:

   Our AMA: (1) supports equitable access to the 10 Essential Public Health Services and the Foundational Public Health Services to protect and promote the health of all people in all communities ~~updating The Core Public Health Functions Steering Committee's "The 10 Essential Public Health Services" to bring them in line with current and future public health practice~~; (2) encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB); (3) will work with appropriate stakeholders to develop a comprehensive list of minimum necessary programs and services to protect the public health of citizens in all state and local jurisdictions and ensure adequate provisions of public health, including, but not limited to clean water, functional sewage systems, access to vaccines, and other public health standards; and (4) will work with the National Association of City and County Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the Big Cities Health Coalition, the Centers for Disease Control and Prevention (CDC), and other related entities that are working to assess and assure appropriate funding levels, service capacity, and adequate infrastructure of the nation's public health system, including for rural jurisdictions. (Amend HOD Policy)

3. That our AMA reaffirm Policy H-478.980, "Increasing Access to Broadband Internet to Reduce Health Disparities." (Reaffirm HOD Policy)

Fiscal Note: Modest - $1,000 - $5,000

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(A-22)

Introduced by: New York

Subject: Air Quality and the Protection of Citizen Health

Referred to: Reference Committee D

Whereas, The upper Hudson River, located in three counties of New York State has been the site of multiple pollution issues (Ciba-Geigy – Chromium and Cyanide in the Feeder Canal, GE – PCB in the Hudson River)[2,3;]; and

Whereas, The Wheelabrator Waste to Energy Plant and the Leigh Cement Facility are emitting over 300 pounds of heavy metals into the air each year for the last 25 years[4]; and

Whereas, Emission compliance is tested only every 30 months[5] and there is a history of violations to EPA guidelines[6]; and

Whereas, These metallic elements do not disappear from the environment, are considered systemic toxicants that are known to induce multiple organ damage, even at lower levels of exposure, and they are also classified as human carcinogens (known or probable) according to the U.S. Environmental Protection Agency, and the International Agency for Research on Cancer[7]; and

Whereas, Study of the potential ecological risks has revealed that the degree of ecological harm caused by heavy metal dust is very strong in both urban and suburban areas[8]; therefore be it

RESOLVED, That our American Medical Association review the Environmental Protection Agency's guidelines for monitoring the air quality which is emitted from smokestacks, taking into consideration the risks to citizens living downwind of smokestacks (Directive to Take Action); and be it further

RESOLVED, That our AMA develop a report based on a review of the EPA's guidelines for monitoring air quality emitted from smokestacks ensuring that recommendations to protect the public's health are included in the report. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

References:
1 Governor's Cancer Research Initiative – Warren County Cancer Incidence Report
2 https://www.epa.gov/hwcorrectiveactionsites/hazardous-waste-cleanup-ciba-geigy-hercules-plant-queensbury-glen-falls-new
3 https://www.epa.gov/enforcement/case-summary-ge-agrees-further-investigate-upper-hudson-river-floodplain-comprehensive
4 https://www.epa.gov/air-emissions-inventories/2014-national-emissions-inventory-nei-data
5 https://poststar.com/news/local/lehigh-cement-gets-state-ok-to-burn-paper-and-plastic/article_a6b97aeb-3a4e-58c4-a789-6188b82e13ae.html
6 https://www.adirondackalmanack.com/2019/12/epa-settles-with-glens-falls-lehigh-cement-co.html
7 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4144270/ Heavy Metals Toxicity and the Environment Paul B Tchounwouet al
8 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5664660/ Int J Environ Res Public Health. 2017 Oct; 14(10): 1159.
9 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4681084/pdf/40557_2015_Article_85.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-22)

Introduced by: New York

Subject: Support for Impairment Research

Referred to: Reference Committee D

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1 Whereas, There has been a proliferation of new and designer recreational drugs, most of which
2 are difficult to detect; and
3
4 Whereas, One of the leading causes of motor vehicle operator (driver) impairment is fatigue
5 without substance use or abuse; and
6
7 Whereas, There are no biochemical or physiological assays for fatigue, akin to breathalyzer
8 readings for ethanol, leading to undercounting and under appreciation of its relevance; and
9
10 Whereas, Evidence is lacking for reliable and reproducible methods of impairment assessment
11 unrelated to the few easily detectable intoxicants; and
12
13 Whereas, The United States Department of Defense (DOD), the Defense Advanced Research
14 Projects Agency (DARPA), and the Institute of Medicine (IOM) have conducted extensive
15 research on neurocognitive testing to assess alertness and impairment; therefore be it
16
17 RESOLVED, That our American Medical Association study the impairment of drivers and other
18 operators of mechanized vehicles by substances, fatigue, medical or mental health conditions,
19 and that this report include whether there are office or hospital-based methods to efficiently and
20 effectively assess impairment of drivers with recommendations for further research that may be
21 needed. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

References:
1. Human Performance Under Sustained Operations
2. Identifying Cognitive State from Eye Metrics
3. NASA's Evidence Reports on Human Health Risks
4. Neurocognitive Monitors – Toward the Prevention of Cognitive Performance Decrements
5. Operational Neuroscience – Neurophysiological Measures in Applied Environments
6. Task Performance and Eye Activity – Predicting Behavior Relating to Cognitive Workload
7. World Anti-Doping Agency – Athlete Biological Passport Guidelines

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(A-22)

Introduced by: Women Physicians Section

Subject: Addressing Maternal Discrimination and Support for Flexible Family Leave

Referred to: Reference Committee D

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1 Whereas, Findings from a study by Adesoye, Mangurian, Choo et al. on physician mothers and
2 their experiences with workplace discrimination indicated that 77.9% of the respondents
3 experienced some form of discrimination;[1] and
4
5 Whereas, Of these respondents, 66.3% of physician mothers reported experiencing gender
6 discrimination and 35.8% reported experiencing maternal discrimination, which is defined as
7 self-reported discrimination based on pregnancy, maternity leave, or breastfeeding;[1] and
8
9 Whereas, Employment laws, such as the Pregnancy Discrimination Act and the Title VII of the
10 Civil Rights Act of 1964, protects individuals from discrimination based on protected class such
11 as, sex, gender and pregnancy;[2] and
12
13 Whereas, The Fair Labor Standards Act includes some breastfeeding protections and
14 requirements for maternity leave but no protections for any additional leaves dealing with
15 parenting needs ;[3] and
16
17 Whereas, Maternal discrimination was associated with higher self-reported burnout (45.9% in
18 physicians experiencing maternal discrimination compared to 33.9% burnout in those not
19 experiencing maternal discrimination) even prior to the pandemic;[1] and
20
21 Whereas, Findings from a study by Templeton, Bernstein, Sukhera, et al. noted that women
22 who are employed full time spend an additional 8.5 hours per week on childcare and other
23 domestic activities which was before the demands of virtual schooling and homeschooling;[4] and
24
25 Whereas, Homeschooling rates have more than tripled during the pandemic due to educational
26 needs and health concerns;[6] and
27
28 Whereas, Across the country almost two-thirds of parents say their children have switched to
29 online learning which requires adult supervision;[7] and
30
31 Whereas, Mothers of young children have lost four to five times as many work hours compared
32 to fathers in the pandemic due to women taking on the majority of childcare responsibilities;[7]
33 and
34
35 Whereas, Male physicians are increasingly expressing interest in flexible family leave and work
36 options, yet female physicians continue to bear primary responsibility for caregiving and may
37 face more challenges in aligning their career goals with family needs; and

Whereas, Conflicts between work and life responsibilities, which have been exacerbated due to the pandemic, can have adverse consequences for women physicians, leading to further discrimination; and

Whereas, AMA Policy H-405.954, "Parental Leave," supports the establishment and expansion of paid parental leave; calls for improved social and economic support for paid family leave to care for newborns, infants and young children; and advocates for federal tax incentives to support early child care and unpaid child care by extended family members; therefore be it

RESOLVED, That our American Medical Association encourage key stakeholders to implement policies and programs that help protect against maternal discrimination and promote work-life integration for physician parents, which should encompass prenatal care, parental leave, and flexibility for childcare (New HOD Policy); and be it further

RESOLVED, That our AMA urge key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/01/22

References:
1. Adesoye T, Mangurian C, Choo EK, et al. Perceived Discrimination Experienced by Physician Mothers and Desired Workplace Changes: A Cross-sectional Survey. *JAMA Intern Med*. 2017;177(7):1033-1036.
2. U.S. Equal Employment Opportunity Commission. Available at https://www.eeoc.gov/laws/types/. Accessed 3/2/2020.
3. Section 7(r), Fair Labor Standards Act - Break Time for Nursing Mothers Provision. Available at https://www.dol.gov/agencies/whd/nursing-mothers/law. Accessed 3/2/2020.
4. Templeton K, Bernstein CA, Sukhera J, et al. Gender-Based Differences in Burnout: Issues Faced by Women Physicians. Available at https://nam.edu/gender-based-differences-in-burnout-issues-faced-by-women-physicians/. Accessed 3/10/2020.
5. Eggleston C, Fields J. Census Bureau's Household Pulse Survey Shows Significant Increase in Homeschooling Rates in Fall 2020. https://www.census.gov/library/stories/2021/03/homeschooling-on-the-rise-during-covid-19-pandemic.html
6. Henderson T. Mothers Are 3 Times More Likely Than Fathers to Have Lost Jobs in Pandemic. Pew Stateline Article. 9/28/2020. https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/09/28/mothers-are-3-times-more-likely-than-fathers-to-have-lost-jobs-in-pandemic

RELEVANT AMA POLICY

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.
13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.
Citation: (CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14)

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

9.5.5 Gender Discrimination in Medicine
Inequality of professional status in medicine among individuals based on gender can compromise patient care, undermine trust, and damage the working environment. Physician leaders in medical schools and medical institutions should advocate for increased leadership in medicine among individuals of underrepresented genders and equitable compensation for all physicians.
Collectively, physicians should actively advocate for and develop family-friendly policies that:
(a) Promote fairness in the workplace, including providing for:
(i) retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family;
(ii) on-site child care services for dependent children;
(iii) job security for physicians who are temporarily not in practice due to pregnancy or family obligations.
(b) Promote fairness in academic medical settings by:
(i) ensuring that tenure decisions make allowance for family obligations by giving faculty members longer to achieve standards for promotion and tenure;
(ii) establish more reasonable guidelines regarding the quantity and timing of published material needed for promotion or tenure that emphasize quality over quantity and encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research;
(iii) fairly distribute teaching, clinical, research, administrative responsibilities, and access to tenure tracks;
(iv) structuring the mentoring process through a fair and visible system.
(c) Take steps to mitigate gender bias in research and publication.
AMA Principles of Medical Ethics: II,VII
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(A-22)

Introduced by: American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association

Subject: Weapons in Correctional Healthcare Settings

Referred to: Reference Committee D

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1 Whereas, The required carrying of rapid rotation baton by all law enforcement officers is being
2 introduced into some Mental Health Units in federal correctional facilities in 2021; and
3
4 Whereas, Physicians in federal correctional healthcare settings who are employed by the
5 Federal Bureau of Prisons are considered law enforcement officers; and
6
7 Whereas, Weapons are here defined in the CMS State Operations Manual: CMS State
8 Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for
9 Hospitals Section 482.13(e) as "includes, but is not limited to, pepper spray, mace, nightsticks,
10 tazers [sic], cattle prods, stun guns, and pistols." (CMS, 2020); and
11
12 Whereas, Eighty percent of violent incidents in hospitals are by patients towards staff. Incidents
13 of serious workplace violence (requiring days off work) are four times more common in
14 healthcare settings than in private industry, so an intentional plan and response to reduce
15 workplace violence is indicated (OSHA, 2015); and
16
17 Whereas, The American Psychiatric Association does not support the use of weapons as a
18 clinical response in the management of patient behavioral dyscontrol in emergency room and
19 inpatient settings because such use conflicts with the therapeutic mission of hospitals (APA,
20 2018); and
21
22 Whereas, Patients who pose a risk of harm to others should be managed by clinical staff using
23 clinical approaches. These clinical approaches will typically involve psychological interpersonal
24 interventions and when less restrictive alternatives fail, the use of involuntary emergency
25 medication, physical seclusion, and physical or mechanical restraint, following guidelines issued
26 by The Joint Commission and CMS. (APA, 2018, Allen et al, 2005); and
27
28 Whereas, The National Commission on Correctional Health Care supports the active prevention
29 of violence through nonphysical methods to prevent and/or control disruptive behaviors
30 including a balanced biopsychosocial approach (NCCHC, 2013); and
31
32 Whereas, Our *AMA Code of Ethics* notes "Physicians have civic duties, but medical ethics do
33 not require a physician to carry out civic duties that contradict fundamental principles of medical
34 ethics, such as the duty to avoid doing harm" (AMA Code of Ethics Opinion 9.7.2); and
35
36 Whereas, Our *AMA Code of Ethics* notes "Individual physicians who provide care under court
37 order should: Participate only if the procedure being mandated is therapeutically efficacious and
38 is therefore undoubtedly not a form of punishment or solely a mechanism of social control."

(AMA Code of Ethics Opinion 9.7.2); and

Whereas, Our *AMA Code of Ethics* notes "Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely" (AMA Code of Ethics Opinion 1.1.7); and

Whereas, The presence of weapons from any source is likely to increase safety concerns without added safety for patients or staff; and

Whereas, The presence of weapons within any healthcare facility may erode the physician-patient relationship, limit access to care, and increase the vulnerability of those individuals and communities who have experienced systemic racism and violence from law enforcement officers (Liebschutz et al., 2010); and

Whereas, The presence of weapons within correctional healthcare facilities may trigger aggression and agitation worsening behavioral dysregulation via the weapons effect (Berkowitz and Le Page, 1967); therefore be it

RESOLVED, That our American Medical Association advocate that physicians not be required to carry or use weapons in correctional facilities where they provide clinical care (Directive to Take Action); and be it further

RESOLVED, That our AMA study and make recommendations regarding the presence of weapons in correctional healthcare facilities. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/05/22

References:

Allen MH, Currier GW, Carpenter D, Ross RW, Docherty JP; Expert Consensus Panel for Behavioral Emergencies 2005. The expert consensus guideline series. Treatment of behavioral emergencies 2005. J Psychiatr Pract. 2005 Nov;11 Suppl 1:5-108; quiz 110-2. PubMed PMID: 16319571. https://pubmed.ncbi.nlm.nih.gov/11500996/

American Psychiatric Association (2018) Position Statement on Weapons Use in Hospitals and Patient Safety Accessed 2/22/21 https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Weapons-Use-in-Hospitals-and-Patient-Safety.pdf

AMA Code of Ethics (2021) Code of Medical Ethics Opinion 1.1.7 Physician Exercise of Conscience Accessed 2/22/21 https://www.ama-assn.org/delivering-care/ethics/physician-exercise-conscience

AMA Code of Ethics (2021) Code of Medical Ethics Opinion 9.7.2 Court-Initiated Medical Treatment in Criminal Cases Accessed 2/22/21 https://www.ama-assn.org/delivering-care/ethics/court-initiated-medical-treatment-criminal-cases

Berkowitz, L. & Le Page, A, (1967) Weapons as Aggression-Eliciting Stimuli *Journal of Personality and Social Psychology, 7, 202-207*

CMS (2020) State Operations Manual Accessed 2/22/21 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

Liebschutz, J., Schwartz, S., Hoyte, J., Conoscenti, L., Christain Sr., AB, Muhammad, L., Harper, D., James, T., (2010) A chasm between injury and care: experiences of black male victims of violence The Journal of Trauma 2010 Dec;69(6):1372-8. doi: 10.1097/TA.0b013e3181e74fcf. https://pubmed.ncbi.nlm.nih.gov/20838259/

National Commission on Correctional Health Care (2013) Position Statement: Prevention of Violence in Correctional Settings Accessed 2/22/21 https://www.ncchc.org/filebin/Positions/Prevention_of_Violence.pdf

OSHA (2015) Workplace Violence in Healthcare: Understanding the Challenge. U.S. Department of Labor Occupational Safety and Health Administration. OSHA 3826 - 12/2015 https://www.osha.gov/Publications/OSHA3826.pdf

RELEVANT AMA POLICY

Use of Conducted Electrical Devices by Law Enforcement Agencies H-145.977
Our AMA: (1) recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) that is modeled after available national guidelines; (2) encourages additional independent research involving actual field deployment of CEDs to better understand the risks and benefits under conditions of actual use. Federal, state, and local agencies should accurately report and analyze the parameters of CED use in field applications; and (3) policy is that law enforcement departments and agencies have a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to CEDs
Citation: (CSAPH Rep. 6, A-09; Modified: Res. 501, A-14)

Guns in Hospitals H-215.977
1. The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention:
A. Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted.
B. The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs.
C. Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.
D. Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included.
E. Policies should undergo periodic reassessment and evaluation.
F. Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.
2. Our AMA will advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present
Citation: BOT Rep. 23, I-94; Reaffirmation I-03; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 2, I-10; Appended: Res. 426, A-16

Policing Reform H-65.954
Our AMA: (1) recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color; (2) will work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers; (3) will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures; and (4) will advocate for legislation and regulations which promote trauma-informed, community-based safety practices.
Citation: Res. 410, I-20; Reaffirmed: CSAPH Rep. 2, A-21; Reaffirmed: BOT Rep. 2, I-21

Mental Health Crisis Interventions H-345.972
Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in

crisis intervention training programs; and (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities.
Citation: Res. 923, I-15; Appended: Res. 220, I-18; Reaffirmed: CSAPH Rep. 2, A-21; Reaffirmed: BOT Rep. 2, I-21

Preventing Violent Acts Against Health Care Providers D-515.983
Our AMA will (a) continue to work with other appropriate organizations to prevent acts of violence against health care providers and improve the safety and security of providers while engaged in caring for patients; and (b) widely disseminate information on effective workplace violence prevention interventions in the health care setting as well as opportunities for training.
Citation: Res. 437, A-08; Modified: CSAPH Rep. 2, I-10; Appended: Res. 607, A-15; Modified: CSAPH Rep. 07, A-16

Health Care While Incarcerated H-430.986
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children’s Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
Citation: CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(A-22)

Introduced by: Medical Student Section

Subject: Universal Childcare and Preschool

Referred to: Reference Committee D

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1 Whereas, In the 2019-2020 school year, only 34% of 4-year-olds and 6% of 3-year-olds were
2 enrolled in state pre-kindergarten[1]; and
3
4 Whereas, The COVID-19 pandemic caused a sharp decline in preschool enrollment, quality
5 standards, teacher qualifications, and state funding[1,2]; and
6
7 Whereas, Research has demonstrated that participation in preschool improves access to
8 pediatric preventive care and is linked to decreases in child mortality, increases in
9 immunizations, reductions in hospitalizations for accidents or injuries, and additional avenues
10 for screening, diagnosis, and care for pediatric patients with ADHD[3-5]; and
11
12 Whereas, Early care and education programs have been shown to lead to long-term
13 improvements in cardiovascular and metabolic health through adolescence and adulthood, as
14 well as reduced smoking and obesity[3,6-8]; and
15
16 Whereas, Universal child care and preschool are avenues for capturing child maltreatment
17 cases because of the crucial role that school personnel play in recognizing, reporting, and
18 preventing child abuse and neglect[9]; and
19
20 Whereas, Childcare attendance is associated with improved cognitive abilities and mitigates the
21 increase in externalizing behaviors observed in children exposed to early adversity[10]; and
22
23 Whereas, Children who participate in early childhood education have higher kindergarten scores
24 in reading, mathematics, cognitive flexibility, and approaches to learning[11]; and
25
26 Whereas, A 2021 JAMA Pediatrics study determined that, for children of mothers with a lower
27 education level, childcare attendance was positively associated with academic achievement at
28 age 16[12]; and
29
30 Whereas, High-quality childcare and early education are shown to have positive effects on the
31 mother-child relationship, maternal wellbeing, and physical and mental, short- and long-term
32 health outcomes for children[3,13-15]; and
33
34 Whereas, Maternal mental health, including maternal depression, and life satisfaction improved
35 after implementation of universal child care in Canada and maternal wellbeing improved after
36 implementation of publicly funded childcare in Germany[16-17]; and
37
38 Whereas, In 2020, the Department of Labor estimated that there were 20.1 million employed
39 Americans with children under the age of six[18]; and

Whereas, A 2020 study of childcare facility closures published in JAMA Health Forum indicated that "state-level childcare facility closures were associated with greater reductions in employment among women compared to men" for parents of children under the age of six[19]; and

Whereas, There are significant racial and ethnic inequities in access to federal childcare subsidies as compared to the national average of 12%, with only 7% of Native American and Alaska Native, 6% of Hispanic/Latino, and 3% of Asian eligible children being served by the Child Care Development Block Grant subsidies in 2016[20]; and

Whereas, 57.3% of Hispanic/Latino and 60.2% of American Indian and Alaska Native populations live in childcare deserts (defined as "areas with an insufficient supply of licensed childcare"), compared to the overall population at 50.5%[21]; and

Whereas, Children from families with high socioeconomic status (SES) are more likely to attend early childhood education programs, with 69% of kindergarteners from high SES families and only 44% from low SES families[11]; and

Whereas, The Child Care and Development Fund is the primary source of financial childcare assistance for low-income families, but, according to the U.S. Department of Health & Human Services, it served only 15% of the 13.3 million children meeting federal eligibility parameters in 2016[22]; and

Whereas, Only five states, District of Columbia, New Jersey, North Carolina, Oklahoma, and West Virginia, fully fund high-quality full-day pre-K, as determined by quality benchmarks set by the National Institute for Early Education Research[1]; and

Whereas, There is a growing recognition of the importance of universal child care and preschool that is reflected by nationwide initiatives like the Senate's Improving Child Care for Working Families Act of 2021 and the Administration's American Families Plan which will provide universal free preschool and limit childcare costs to less than 7% of household income[23,24]; and

Whereas, The American Academy of Pediatrics Council on Early Childhood published a 2016 position statement stating that "high-quality early education and child care for young children improves physical and cognitive outcomes for the children and can result in enhanced school readiness"[25]; and

Whereas, While our AMA has some existing policies (D-200.974, H-310.912, G-600.115, H-95.916, H-440.970, H-150.927, and H-245.979) supporting access to childcare for healthcare professionals and patients in substance use treatment facilities, funding for Head Start (a federal childcare and preschool program for low-income families), and public health protections in childcare settings, our AMA does not currently have policy on universal, affordable access to childcare; and

Whereas, While AMA Policy H-60.917 states that our AMA "will issue a call to action to...to propose strategies...to further the access of all children to...early childhood education," this does not ask our AMA to advocate for proposed strategies currently being debated in Congress and state governments, and "early childhood education" in that context appears to refer to existing public education from kindergarten to third grade and not specifically childcare or preschool, which are more limited in availability and require greater advocacy to expand; therefore be it

1 RESOLVED, That our American Medical Association advocate for universal access to high-
2 quality and affordable childcare and preschool. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 04/08/22

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RELEVANT AMA POLICY

Supporting Child Care for Health Care Professionals D-200.974
Our AMA will work with interested stakeholders to investigate solutions for innovative childcare policies and flexible working environments for all health care professionals (in particular, medical students and physician trainees). Res. 309, A-21

Preserving Childcare at AMA Meetings G-600.115
Our AMA will arrange onsite supervised childcare at no cost to members attending AMA Annual and Interim meetings. Res. 602, I-19

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917
1. Our AMA: (a) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (b) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (c) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.
2. Our AMA will work with: (a) the Health and Human Services Department (HHS) and Department of Education (DOE) to raise awareness about the health benefits of education; and (b) the Centers for Disease Control and Prevention and other stakeholders to promote a meaningful health curriculum (including nutrition) for grades kindergarten through 12.
3. Our AMA will encourage the U.S. Department of Education and Department of Labor to develop policies and initiatives in support of students from marginalized backgrounds that: (a) decrease the educational opportunity gap; (b) increase participation in high school Advanced Placement courses; and (c) increase the high school graduation rate. Res. 910, I-16; Appended: Res. 410, A-19; Appended: CME Rep. 5, A-21

Childcare Availability for Persons Receiving Substance Use Disorder Treatment H-95.916
Our AMA supports the implementation of childcare resources in existing substance use treatment facilities and acknowledges childcare infrastructure and support as a major priority in the development of new substance use programs. Res. 519, A-19

Opposition to Proposed Budget Cuts in WIC and Head Start H-245.979
The AMA opposes reductions in funding for WIC and Head Start and other programs that significantly impact child and infant health and education. Res. 246, I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14

Parental Leave H-405.954
1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and

promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.
Res. 215, I-16; Appended: BOT Rep. 11, A-19

Nonmedical Exemptions from Immunizations H-440.970
1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large.
Therefore, our AMA (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.
2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to (a) eliminate non-medical exemptions from mandated immunizations and (b) limit medical vaccine exemption authority to only licensed physicians.
Citation: CSA Rep. B, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 10, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 416, A-19; Modified: Res. 207, I-21

Strategies to Reduce the Consumption of Beverages with Added Sweeteners H-150.927
Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption, and support evidence-based strategies to reduce the consumption of SSBs, including but not limited to, excise taxes on SSBs, removing options to purchase SSBs in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption, such as controlling portion sizes; limiting options to purchase or access SSBs in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and replacing SSBs with healthier beverage choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage choices for students. CSAPH Rep. 03, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(A-22)

Introduced by: American Association of Public Health Physicians

Subject: COVID-19 Preventive Measures for Correctional Facilities: AMA Policy Position

Referred to: Reference Committee D

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1 Whereas, Correctional facilities are, by their nature, congregate facilities[i]; and
2
3 Whereas, Those incarcerated should be tested for COVID upon entry when recommended by
4 the CDC; and if positive isolated for time periods recommended by the CDC; and
5
6 Whereas, Those incarcerated, and test negative are quarantined prior to enter into the general
7 population according to current CDC guidelines [ii]; and
8
9 Whereas, Despite these measures there may continue to be a higher rate of COVID-19
10 transmission in correctional facilities than in the local communities;[iii] and
11
12 Whereas, The probable source of these COVID-19 infections is by those entering and exiting on
13 a frequent, sometimes daily, basis; and
14
15 Whereas, Less than 50% of correctional employees are fully vaccinated in accordance with
16 CDC guidelines against COVID-19 [iv]; and
17
18 Whereas, Requiring vaccination does not result in increased employment vacancies [v] [vi] [vii];
19 and
20
21 Whereas, COVID vaccination and masks have been shown to decrease the spread of
22 COVID-19 and the need for hospitalization [viii]; and
23
24 Whereas, Our AMA has taken a position on appropriate preventive measures [ix]; and
25
26 Whereas, This resolution should not be considered a mandate but as a position statement,
27 therefore be it
28
29 RESOLVED, That our American Medical Association advocate for all employees working in a
30 correctional facility to be up to date with vaccinations against COVID-19, unless there is a valid
31 medical contraindication/religious exception (Directive to Take Action); and be it further
32
33 RESOLVED, That our AMA advocate for all employees not up to date with vaccination for
34 COVID-19 to be COVID rapid tested each time they enter a correctional facility (Directive to
35 Take Action); and be it further

RESOLVED, That our AMA advocate for correctional facility policies that require non-employed, non-residents (e.g. visitors, contractors, etc.) to either show evidence of being up to date for COVID-19 or show proof of negative COVID test completed within 24 hours prior to each entry into a correctional facility (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that all people inside a correctional facility wear an appropriate mask at all times, except while eating or drinking or at a safe (6 ft.) distance from anyone else if local transmission rate is above low risk as determined by the Centers for Disease Control and Prevention (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that correctional facilities be able to request and receive all necessary funding for the above endemic COVID-19 vaccination and testing. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

[i] Mary Devereaux Hutton et al., Tuberculosis in Nursing Homes and Correctional Facilities: results of a 29-State Survey, CDC, at 2 (Nov. 1990), https://bit.ly/3I51ySJ; see also, e.g., Joseph A. Bick, Infection Control in Jails and Prisons, 45 Clinical Infectious Diseases 1047 (2007),https://bit.ly/3qrND34.
[ii] https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html
[iii] COVID-19, State of New Jersey Department of Corrections ("NJDOC"), https://bit.ly/3Hj0yKQ
[iv] With the majority of corrections officers declining the COVID-19 vaccine, incarcerated people are still at serious risk. https://www.prisonpolicy.org/blog/2021/04/22/vaccinerefusal/
[v] Jack J. Barry et al., Unvaccinated Workers Say They'd Rather Quit Than Get a Shot, but Data Suggest Otherwise, Scientific American (Sept. 24, 2021), https://bit.ly/3kUYKOT.
[vi] Compare New Jersey COVID-19 Dashboard, (listing 1,835,533 cases in New Jersey), with QuickFacts: New Jersey, U.S. Census Bureau, https://bit.ly/3GcGhFy (last visited Feb. 4, 2022) (listing New Jersey population as 9,267,130).
[vii] Compare COVID-19, (listing 10,139 positive COVID-19 cases among incarcerated populations in NJDOC facilities), with Offender Characteristics Report on January 1, 2021, NJDOC, https://bit.ly/3L88jpt (in most recent publicly available data, listing total incarcerated individuals in NJDOC facilities as 12,808) and Total Inmates in New Jersey State Correctional Institutions and Satellite Units, State of New Jersey Department of Corrections (2020), https://bit.ly/3ukd4pJ (listing total incarcerated individuals in NJDOC facilities as 18,477 in 2020
[viii] What do we know about covid vaccines and preventing transmission? BMJ 2022;376:o298
[ix] Press Release, American Medical Ass'n, AMA, AHA, ANA urge vaccinations as U.S. reaches 750,000 COVID-19 deaths (Nov. 4, 2021), https://bit.ly/3C07CIS.
[x] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html?s_cid=11747:cdc%20up%20to%20date%20vaccine:sem.ga:p:RG:GM:gen:PTN:FY22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(A-22)

Introduced by: American Thoracic Society

Subject: Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections

Referred to: Reference Committee D

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1 Whereas, Law enforcement and correctional officers at the bedside of a patient in their custody
2 have ethical guidelines, legal obligations, and operating procedures that are separate--and
3 potentially in tension with--those of the various clinicians caring for that patient in an acute care
4 setting. Lack of clarity or disagreement can arise even when all parties are acting in good faith
5 to fulfil their respective duties (1,2); and
6
7 Whereas, Clinicians in acute care environments often lack clear guidance on when and how law
8 enforcement or correctional officers can or should dictate parameters of patient care in ways
9 that are not clinically indicated, including but not limited to: restraint and officer presence at the
10 bedside, documentation of injuries, collection of evidence, laboratory testing, end-of-life decision
11 making, organ donation, visitor restrictions, and sharing of protected health information (PHI)
12 (3); and
13
14 Whereas, Hospital liaison teams to help guide interactions between clinicians and law
15 enforcement agencies may improve communication and coordination while also providing
16 patients, their surrogates, and members of the healthcare team with autonomy and privacy
17 protections required by law and in concordance with professional ethical standards (4,5); and
18
19 Whereas, Existing AMA policy does not provide adequate actionable guidance to clinicians
20 and/or law enforcement officials at the bedside, including policy surrounding disclosure of PHI to
21 law enforcement (H-315.975); therefore be it
22
23 RESOLVED, That our American Medical Association study best practices for interactions
24 between hospitals, clinicians, and members of law enforcement or correctional agencies to
25 ensure that patients in custody of such law enforcement or correctional agencies (including
26 patients without decision-making capacity), their surrogates, and the health care providers
27 caring for them are provided the autonomy and privacy protections afforded to them by law and
28 in concordance with professional ethical standards and report its findings to the AMA House of
29 Delegates by the 2023 Annual Meeting. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

1. Law Enforcement Code of Ethics: International Association of Chiefs of Police; [Available from: https://www.theiacp.org/resources/law-enforcement-code-of-ethics.
2. Code of Medical Ethics: American Medical Association; 2022 [Available from: https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview.
3. Griffith MF, O'Brien JK, Sergew A, Wynia MK, Carno M, Akgün KM. Profiling, Privacy, and Protection: Ethical Guidance When Police Are Present at Bedside. Ann Am Thorac Soc. 2022.
4. Hospital Coordination with Law Enforcement: Hospital Guidance Document: Greater New York Hospital Association; [Available from: https://www.gnyha.org/wp-content/uploads/2017/08/NYPD_Coordination_FINAL_6Dec2016.pdf.
5. Guidelines for Releasing Patient Information to Law Enforcement
American Hospital Association and National Association of Police Organizations; 2018 [Available from: https://www.aha.org/system/files/2018-03/guidelinesreleasinginfo.pdf.

RELEVANT AMA POLICY

Police, Payer, and Government Access to Patient Health Information H-315.975

(1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define "health care operations" narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.
(2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.
(3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.
(4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.
(5) Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.
Citation: Res. 246, A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmed: BOT Rep. 16, I-21

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921

Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.
Citation: Res. 232, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(A-22)

Introduced by: Illinois

Subject: Supporting Increased Research on Implementation of Nonviolent De-escalation Training and Mental Illness Awareness in Law Enforcement

Referred to: Reference Committee D

Whereas, The risk for an individual with untreated mental illness of being killed during a police incident is one in four; and

Whereas, Government agencies collect data from independent databases as they are more complete than data procured by government agencies, however the media and independent sources have incomplete data due to a lack of a national government database; and

Whereas, This leads to a feedback loop of misinformation where the true statistics surrounding police-related fatalities are unknown; and

Whereas, Though improvements have been made to the Bureau of Justice Statistics' Arrest-Related Deaths (ARD) program, there is still an estimated 31-41% cases of fatal shootings that are still believed to be missed, due to the program not meeting the agency's quality standards; and

Whereas, These downfalls in reporting of fatal police shootings by government agencies miss the target even further in regard to mental illness's role in these deadly encounters, leading to audits due to inability to meet the agencies quality standards; and

Whereas, De-escalation tactics and techniques are actions used by officers, when safe and feasible without compromising law enforcement priorities, that seek to minimize the likelihood of the need to use force during an incident and increase the likelihood of voluntary compliance; and

Whereas, De-escalation tactics such as crisis intervention training, when used by officers are safe without compromising law enforcement priorities, and minimize the need for force in encounters, and increase the likelihood of voluntary compliance by a civilian; and

Whereas, De-escalation training has been shown to be the most successful at increasing self-reported knowledge and confidence amongst trainees; and

Whereas, Greater knowledge of causes and precipitating factors of aggression and violence as well as improved capabilities to handle those emotions promotes prevention and management of these behaviors; therefore, be it

RESOLVED, That our American Medical Association support increased research on non-violent de-escalation tactics for law enforcement encounters with the mentally ill (New HOD Policy); and be it further

1 RESOLVED, That our AMA support research of fatal encounters with law enforcement and the
2 prevention thereof. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

References:

1. Fuller DA, Lamb HR, Biasotti M, Snook J. Overlooked in the Undercounted - The Role of Mental Illness in Fatal Law Enforcement Encounters. Overlooked in the Undercounted - Treatment Advocacy Center. https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in -the-undercounted.pdf Published December 2015.
2. Rogers MS, McNiel DE, Binder RL. Effectiveness of Police Crisis Intervention Training Programs. J Am Acad Psychiatry Law. 2019 Dec;47(4):414-421. doi: 10.29158/JAAPL.003863-19. Epub 2019 Sep 24. PMID: 31551327.
3. Banks D, Ruddle P, Kennedy E, Planty MG. Arrest-Related Deaths Program Redesign Study, 2015-16: Preliminary Findings. Washington DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; 2016. No. NCJ 250112
4. Diaz A. 8.100 - De-Escalation. 8.100 - De-Escalation - Police Manual. https://www.seattle.gov/police-manual/title-8---use-of-force/8100---de-escalation Published September 15, 2019.
5. Engel RS, McManus HD, Herold TD. The Deafening Demand for De-escalation Training: A Systematic Review and Call for Evidence in Police Use of Force Reform. https://www.theiacp.org/sites/default/files/IACP_UC_De-escalation%20Systematic%20Review.pdf Published 2017

RELEVANT AMA POLICY

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955

Our AMA:
1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.
Citation: Res. 406, A-16; Modified: BOT Rep. 28, A-18; Reaffirmed: BOT Rep. 2, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(A-22)

Introduced by: Illinois

Subject: Increasing HPV Vaccination Rates in Rural Communities

Referred to: Reference Committee D

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1 Whereas, Recent studies have shown only 28.3% of adolescents living in non-metropolitan
2 statistical areas of Illinois had received all recommended doses of the HPV vaccine as
3 compared to 61.2% of adolescents living in metropolitan statistical areas around the state who
4 had received all recommended doses; and
5
6 Whereas, The disparity between urban and rural HPV vaccine rates is similar across the United
7 States, with lower vaccination rates in rural areas; and
8
9 Whereas, In the US it is estimated there were 32,100 cases of HPV related cancers from 2012-
10 2016 that are targets for the 9vHPV vaccine; therefore be it
11
12 RESOLVED, That our American Medical Association advocate for increased HPV vaccination
13 access and education in rural communities. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

References:

"2018 Adolescent Human Papillomavirus (HPV) Vaccination Coverage Dashboard." 2018 Adolescent Human Papillomavirus (HPV) Vaccination Coverage Dashboard, Centers for Disease Control and Prevention, 2018, www.cdc.gov/vaccines/imz-managers/coverage/teenvaxview/data-reports/hpv/dashboard/2018.html

Senkomago V, Henley SJ, Thomas CC, Mix JM, Markowitz LE, Saraiya M. Human Papillomavirus-Attributable Cancers-United States, 2012-2016. MMWR Morb Mortal Wkly Rep 2019; 68: 724-728 https://www.cdc.gov/mmwr/volumes/68/wr/mm6833a3.htm

RELEVANT AMA POLICY

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872
1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.
3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
Citation: (Res. 503, A-07; Appended: Res. 6, A-12)

Human Papillomavirus (HPV) Inclusion in School Education Curricula D-170.995
Our AMA will: (1) strongly urge existing school health education programs to emphasize the high prevalence of human papillomavirus in all genders, the causal relationship of HPV to cancer and genital lesions, and the importance of routine pap tests in the early detection of cancer; (2) urge that students and parents be educated about HPV and the availability of the HPV vaccine; and (3) support appropriate stakeholders to increase public awareness of HPV vaccine effectiveness for all genders against HPV-related cancers.
Citation: Res. 418, A-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: Res. 404, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(A-22)

Introduced by: Illinois

Subject: Increasing Education for School Staff to Recognize Prodromal Symptoms of Schizophrenia in Teens and Young Adults to Increase Early Intervention

Referred to: Reference Committee D

Whereas, There are three phases of schizophrenia: prodromal, active and residual; and

Whereas, Prepsychotic prodromal stage lasts for a mean duration of 4.8 years and a psychotic prephase lasts for a mean duration of 1.3 years; and

Whereas, Almost 70% of people living with schizophrenia receive inadequate treatment; and

Whereas, The early detection of symptoms of the prodrome of psychotic illness in order of increased frequency include: reduced concentration and attention, reduced drive and motivation and anergia, depressed mood, sleep disturbance, anxiety, social withdrawal, suspiciousness and deterioration in role functioning, irritability; and

Whereas, Late detection and treatment of prolonged psychosis result in worse outcomes; and

Whereas, If early prodromal symptoms of a psychotic illness are detected, referral for further psychiatric evaluation should be considered; and

Whereas, Establishing care with patients demonstrating prodromal symptoms of a psychotic illness is an important part of their current and future outcomes; and

Whereas, Only a systematic implementation of these models of care in the national health care systems will render these strategies accessible to the 23 million people worldwide suffering from the most severe psychiatric disorders; therefore be it

RESOLVED, That our American Medical Association work with the American Psychiatric Association and other entities to support research of establishing education programs to teach high school and university staff to recognize the early prodromal symptoms of schizophrenia to increase early intervention. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

References:

1.Larson MK, Walker EF, Compton MT. Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. 2010;10(8):1347-1359. doi:10.1586/ern.10.93
2.Häfner H, Maurer K. Early detection of schizophrenia: current evidence and future perspectives. World Psychiatry. 2006;5(3):130-138.
3.Schizophrenia. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/schizophrenia. October 4, 2019.
4.Fusar-Poli P, McGorry PD, Kane JM. Improving outcomes of first-episode psychosis: an overview. World Psychiatry. 2017;16(3):251-265. doi:10.1002/wps.20446

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(A-22)

Introduced by: Michigan

Subject: Anonymous Prescribing Option for Expedited Partner Therapy

Referred to: Reference Committee D

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1 Whereas, Sexually transmitted infections (STIs) reached an all-time high in the United States in
2 2018 with more than 580,000 cases of gonorrhea and 1.7 million cases of chlamydia, the
3 highest number of chlamydia cases ever reported to the Centers for Disease Control and
4 Prevention (CDC); and
5
6 Whereas, Some data suggests that 40 to 70 percent of male partners do not receive STI
7 treatment; and
8
9 Whereas, Reinfection rates of chlamydia and gonorrhea in women are high, estimated to be
10 13.9 percent and 11.7 percent, respectively; and
11
12 Whereas, Untreated STIs can result in adverse health outcomes including pelvic inflammatory
13 disease, infertility, ectopic pregnancy, and increased HIV risk; and
14
15 Whereas, Expedited Partner Therapy (EPT) is the clinical practice in which a patient diagnosed
16 with chlamydia or gonorrhea may be given medications for themselves and their sex partners
17 without the health care provider first examining the partner; and
18
19 Whereas, Evidence indicates that EPT has improved clinical effectiveness in decreasing
20 recurrent infection compared to other methods of partner treatment; and
21
22 Whereas, EPT has been found to be cost-saving and cost-effective, improves notification of
23 sexual partners of the STI diagnosis, and safe as severe reactions to treatment are so rare that
24 there are no reported percentages; and
25
26 Whereas, Physicians have an ethical duty to not only help their patients but also improve public
27 health, which includes the treatment of their patients' partner(s); and
28
29 Whereas, The practice of EPT is supported by the CDC, the American College of Obstetricians
30 and Gynecologists, the American Academy of Family Physicians, the American Academy of
31 Pediatrics, and the Society for Adolescent Health and Medicine; and
32
33 Whereas, Existing AMA policy (D-440.968, H-440.868) supports the practice of EPT and
34 existing policy states it will work with the CDC to develop tools for health departments and
35 health professionals to facilitate the use of EPT; and
36
37 Whereas, Although EPT is well-supported, there is limited discussion surrounding anonymous
38 prescribing within EPT and current policies do not explicitly address this component of EPT; and

1 Whereas, Most electronic medical record systems do not have the ability to allow a physician to
2 prescribe medications anonymously; therefore be it
3
4 RESOLVED, That our American Medical Association work with electronic medical record
5 vendors to create an anonymous prescribing option for the purpose of expedited partner
6 therapy. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 04/08/22

Sources:
1. New CDC Report: STDs continue to rise in the US. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention; 2019. https://www.cdc.gov/nchhstp/newsroom/2019/2018-STD-surveillance-report-press-release.html
2. Jamison CD, Coleman JS, Mmeje O. Improving women's health and combatting sexually transmitted infections through expedited partner therapy. Journal of Obstetrics & Gynecology. 2019 March; 133(3): 416-422.
3. Hosenfeld CB, Workowski KA, Berman S, Zaidi A, Dyson J, Mosure D, Bolan G, Bauer HM. Repeat infection with chlamydia and gonorrhea among females: a systematic review of the literature. Sexually Transmitted Diseases. 2009 August; 36(8): 478-489.
4. Expedited Partner Therapy. Centers for Disease Control and Prevention; 2019. https://www.cdc.gov/std/ept/default.htm
5. Althaus CL, Turner KM, Mercer CH, Auguste P, Roberts TE, Bell G, Herzog SA, Cassell JA, Edmunds WJ, White PJ, Ward H, Low N. Effectiveness and cost-effectiveness of traditional and new partner notification technologies for curable sexually transmitted infections: observational study, systematic reviews, and mathematical modelling. Health Technologies Assessment. 2014 January; 18(2): 1-100.
6. Gannon-Loew KE, Holland-Hall C, Bonny AE. A review of expedited partner therapy for the management of sexually transmitted infections in adolescents. Journal of Pediatric and Adolescent Gynecology. 2017 June; 30(3): 341-348.
7. DeCoster B, Campo-Engelstein L. Expedited partner therapy: clinical considerations and public health explorations, commentary 1. AMA Journal of Ethics. 2016 March; 18(3): 215-228.

RELEVANT AMA POLICY

Expedited Partner Therapy (Patient-Delivered Partner Therapy) D-440.968
Our AMA will continue to work with the Centers for Disease Control and Prevention as it implements expedited partner therapy, such as through the development of tools for local health departments and health care professionals to facilitate the appropriate use of this therapy.
Citation: CSA Rep. 9, A-05; Appended: CSAPH Rep. 7, A-06; Modified: CSAPH 01, A-16

Expedited Partner Therapy H-440.868
Our AMA supports state legislation that permits physicians to provide expedited partner therapy to patients diagnosed with gonorrhea, chlamydia infection, and other sexually transmitted infections, as supported by scientific evidence and identified by the CDC.
Citation: Sub. Res. 928, I-07; Reaffirmed: CSAPH Rep. 01, A-17; Modified: Res. 902, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(A-22)

Introduced by: Medical Student Section

Subject: Advocating for the Amendment of Chronic Nuisance Ordinances

Referred to: Reference Committee D

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1 Whereas, Chronic nuisance ordinances (CNOs) are municipal laws that aim to lower the crime
2 rate on rental properties by penalizing property owners if repeated incidents of nuisance activity
3 occur over a set period of time (typically 12 months)[1]; and
4
5 Whereas, CNOs are part of a phenomenon called "third-party policing," through which cities
6 require private citizens--in this case property owners--to address criminal or otherwise
7 undesirable behaviors[1]; and
8
9 Whereas, Punishments for violating CNOs may range from warning letters and fines to evictions
10 and building closures, and often involve a "nuisance point system" where a certain number of
11 accumulated points will result in eviction and other actions[1]; and
12
13 Whereas, What qualifies as nuisance activity can vary widely between municipalities, though it
14 is commonly defined as the amount of contact with emergency services, first responders, and
15 police, for criminal behavior that occurs on or near the property, or "alleged nuisance conduct"
16 (assault, harassment, stalking, disorderly conduct, city code violations, noise violations, and
17 others)[2]; and
18
19 Whereas, CNOs have been enacted by an estimated 2,000 municipalities across 44 states as of
20 2014[3]; and
21
22 Whereas, Nuisance ordinances often apply even when a resident was the victim, and not the
23 source, of the nuisance activity, so that CNOs punish tenants who require police and
24 emergency medical assistance by making eviction a consequence of police responses to their
25 homes[1,3,4]; and
26
27 Whereas, The reason for calling the police is not accounted for by most CNOs, so people who
28 experience mental health crises may be deemed perpetrators of nuisance activity for seeking
29 emergency medical assistance at a frequency beyond the threshold established in the CNO and
30 may be threatened with eviction by their landlords[1]; and
31
32 Whereas, Health crises that can count as a CNO violation include drug overdoses: public
33 records from a sample of Northeast Ohio cities found that 10-40% of applications of CNOs are
34 related to a person experiencing a drug overdose, many of which explicitly include violations of
35 criminal drug abuse laws as nuisance[5]; and
36
37 Whereas, CNO nuisance behavior can include the aesthetic appearance of property, such as
38 litter, an un-mowed lawn, or an "unsightly" yard, which can be applied against residents whose
39 physical, mental, or health-related disabilities prevent them from meeting their municipality's
40 maintenance standards[1]; and

Whereas, Cities have fined group homes (organizations that provide community-based residences for people with disabilities) after staff sought police or emergency services assistance responding to their residents' medical emergencies[5]; and

Whereas, Surveys, research, and lawsuits regarding nuisance ordinance enforcement across the country suggest that chronic nuisance ordinances disproportionately impact marginalized populations and people of color, even when the same number of calls are made from privileged neighborhoods[2,6,7]; and

Whereas, There are an estimated 1.3 million women who are the victims of assault by an intimate partner annually, and women have a 25% lifetime risk of intimate partner violence, with a 40% greater chance of experiencing domestic violence for women with disabilities[8,9]; and

Whereas, Congress acknowledges that "women and families across the country are being discriminated against, denied access to, and even evicted from public and subsidized housing because of their status as victims of domestic violence"[8]; and

Whereas, Domestic violence advocates' efforts in the past decades have been focused on educating law enforcement on how to approach and aid victims in escaping the cycle of domestic violence while maintaining their housing, but this initiative is directly threatened by CNOs, as calls about domestic disturbances can result in the eviction of everyone in the household[3,10-13]; and

Whereas, Nuisance ordinances frequently fail to make exceptions for police calls made by residents experiencing domestic violence, and even in cases where exceptions exist, calls placed by survivors of domestic violence are regularly miscategorized and the tenants are punished under the CNO regardless, discouraging victims of domestic violence from seeking help in future assaults[10,14]; and

Whereas, The use of CNOs may contribute to the "double victimization" of domestic violence victims, who may be evicted because of allegations of disturbing other tenants or property damage caused by their abusers[11]; and

Whereas, In June 2017, an appellate court struck down the Village of Groton's nuisance law as unconstitutional under the First Amendment, the reasoning being that it deterred tenants from seeking police assistance, and discouraged people, including domestic violence victims, from reaching out for help[15]; and

Whereas, The data on whether CNOs are effective at accomplishing their goals of reducing nuisance activity are limited[7,12,14]; and

Whereas, Even though Cincinnati reported an overall 22% decrease in nuisance calls from 2006-2010, it is unknown whether this drop is due to underreporting or actual decreases in such behavior[12]; and

Whereas, Housing instability and eviction is associated with a higher risk of depression, anxiety, and suicide, with individuals who lost legal rights to their housing and whose landlords applied for eviction proceedings were four times more likely to commit suicide (OR = 4.42) compared to individuals who had not experienced eviction[16-18]; and

Whereas, The disproportionate impact of CNOs on people of color, with disabilities, and/or victims of domestic violence limit the opportunities for these tenants to find affordable housing in the future, regardless of the circumstances in which they occurred[13]; therefore be it

RESOLVED, That our American Medical Association advocate for amendments to chronic nuisance ordinances that ensure calls made for safety or emergency services are not counted towards nuisance designations (Directive to Take Action); and be it further

RESOLVED, That our AMA support initiatives to (a) gather data on chronic nuisance ordinance enforcement and (b) make that data publicly available to enable easier identification of disparities. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

References:

1. Jarwala A, Singh S. When Disability Is a "Nuisance": How Chronic Nuisance Ordinances Push Residents with Disabilities Out of Their Homes. *Harvard Civil Rights- Civil Liberties Law Review*. July 2019:877-915.
2. Katovich S. More Than a Nuisance: The Outsized Consequence of New York's Nuisance Ordinances. *New York Civil Liberties Union*. 2018.
3. Livanos N. Crime-Free Housing Ordinances: One Call Away from Eviction. Public Interest Law Reporter. 2014;19(2):106-113. http://lawecommons.luc.edu/pilr/vol19/iss2/6.
4. I am Not a Nuisance: Local Ordinances Punish Victims of Crime. *ACLU*. https://www.aclu.org/other/i-am-not-nuisance-local-ordinances-punish-victims-crime. Published 2018. Accessed September 19, 2019.
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7. Desmond M, Valdez N. Unpolicing the Urban Poor: Consequences of Third-Party Policing for Inner-City Women. *American Sociological Review*. 2012;78(1):117-141. doi:10.1177/0003122412470829.
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10. Chronic Nuisance and Crime-Free Ordinances: Endangering the Right of Domestic Violence Survivors to Seek Police Assistance. *ACLU*. https://www.aclu.org/sites/default/files/assets/nuisance_ordinance_issue_summary_-_final.pdf. Published 2019. Accessed August 25, 2019.
11. Lapidus LM. Doubly Victimized: Housing Discrimination Against Victims of Domestic Violence. *American University Journal of Gender Social Policy and Law*. 2003;11(2):377-391.
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15. Bd. of Trustees of Vill. of Groton, 152 A.D.3d at 160-61.
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17. Rojas Y, Stenberg S-Å. Evictions and suicide: a follow-up study of almost 22,000 Swedish households in the wake of the global financial crisis. *J Epidemiol Community Health*. 2016;70(4):409-413. doi:10.1136/jech-2015-206419
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RELEVANT AMA POLICY

Eradicating Homelessness H-160.903
Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
Citation: Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19

Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data H-350.953
Our AMA will: (1) oppose policies that enable racial housing segregation; and (2) advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool.
Citation: Res. 405, A-18

Insurance Discrimination Against Victims of Domestic Violence H-185.976
Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence.
Citation: Res. 814, I-94; Appended: Res. 419, I-00; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(A-22)

Introduced by: Medical Student Section

Subject: Expansion on Comprehensive Sexual Health Education

Referred to: Reference Committee D

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1 Whereas, Data from the Centers for Disease Control and Prevention's Youth Risk Behavior
2 Surveillance System indicate that 41.2% of all high school students are sexually active, and
3 11.5% have had 4 or more partners;[1] and
4
5 Whereas, Of the 39 states and D.C. that mandate some form of sex education, only 12 states
6 mandate that sex education be medically accurate, and 16 states mandate that HIV education
7 be medically accurate;[2,3] and
8
9 Whereas, Comprehensive sex education is defined as a medically accurate, age appropriate
10 and evidenced-based teaching approach which stresses abstinence and other methods of
11 contraception equally in order to prevent negative health outcomes for teenagers;[4] and
12
13 Whereas, A study surveying adolescents aged 15-24 reported over half (60.4% of females and
14 64.6% males) engaging in fellatio within the past year, while fewer than 10% (7.6% females and
15 9.3% males) used a condom;[5] and
16
17 Whereas, There is a lack of knowledge among adolescents regarding the importance of
18 condoms, dental dams and alternative barrier protection methods use during oral sex to prevent
19 the spread of sexually-transmitted infections (STIs);[5–7] and
20
21 Whereas, When sex education is taught, only 20 states and D.C. require provision of
22 information on contraception;[3] and
23
24 Whereas, Several studies have shown parents tasked with teaching their children sexual
25 education frequently needed support in information, motivation, and strategies to achieve
26 competency[8]; and
27
28 Whereas, LGBTQ youth are at higher risk for sexual health complications due to differing sexual
29 practices and behaviors;[9] and
30
31 Whereas, Current sex education initiatives negatively impact transgender youth and their sexual
32 health by failing to appropriately address their behavior, leading rates of HIV more than 4 times
33 the national average, and increased likelihood to experience coerced sexual contact;[9] and
34
35 Whereas, The GLSEN 2013 National School Climate Survey found that fewer than
36 5% of LGBT students had health classes that included positive representations of
37 LGBT-related topics, and among Millennials surveyed in 2015, only 12% said their sex
38 education classes covered same-sex relationships;[2,9,10] and

Whereas, LGBTQ youth are at a significantly higher risk of teen pregnancy involvement (between two and seven times the rate of their heterosexual peers);[11] and

Whereas, When sex education is taught, seven states prohibit sex educators from discussing LGBTQ relationships and identities or require homosexuality to be framed negatively if it is discussed;[3] and

Whereas, In 2010, the federal government redirected funds from abstinence-only programs to evidence-based teen pregnancy prevention programs;[12] and

Whereas, In 2017, 31 federal and state bills were introduced to advance comprehensive sexuality education, but only 4 were enacted or passed;[2,13] and

Whereas, The 2018 CDC School Health Profile determined that only 17.6% of middle schools across all the states taught comprehensive sex education encompassing topics including pregnancy and STIs;[14] and

Whereas, Since 2000, estimated medical costs of $6.5 billion dollars were associated with the treatment of young people with sexually transmitted infections, excluding costs of HIV/AIDS;[15] and

Whereas, Forty states and D.C. require school districts to involve parents in sex education and/or HIV education, of which nearly all states allow parents the option to remove their child from such education;[11] and

Whereas, Some high-risk populations such as teenagers in foster care may not be able to receive adequate reproductive and sexual health education in their home;[16,17] and

Whereas, Regardless of political affiliation, parents overwhelmingly report that sex education is important and should include topics such as puberty, healthy relationships, abstinence, birth control, and STIs;[18] and

Whereas, The rate of teenage pregnancy and STIs in the US has remained consistently higher than many other industrialized countries;[19–21] and

Whereas, The US teen birth rate declined by 9% between 2009 and 2010, with evidence showing that during this time, there was a significant increase in teen use of contraceptives and no significant change in teen sexual activity, highlighting the importance of education on contraception in decreasing teen births[22]; and

Whereas, Studies have found that abstinence-based sex education has insignificant effect on improving teen birth rates and abortion rates, is not effective in delaying initiation of sexual intercourse or changing other sexual risk-taking behaviors, and may actually increase STI rates in states with smaller populations;[23–25] and

Whereas, Comprehensive sex education has been shown to be effective at changing knowledge, attitudes, and behaviors related to sexual health and reproductive knowledge as well as reducing sexual activity, numbers of sexual partners, teen pregnancy, HIV, and STI rates;[23,26–28] and

Whereas, The federal government has recognized the advantages of comprehensive sex education and has dedicated funds for these programs including the Personal Responsibility Education Program (PREP), a state-grant program from the federal government that funds comprehensive sex education;[29,30] and

Whereas, As of 2017, 41 PREP programs that emphasize abstinence and contraception equally with a focus on individualized decision making have been vigorously reviewed, endorsed, and funded by the HHS;[29] and

Whereas, Federal funding has increased the amount of funding for abstinence based programs by 67% since the 2018 Consolidation of Appropriations act;[30] and

Whereas, The American College of Obstetricians and Gynecologists (ACOG), Society for Adolescent Health and Medicine's (SAHM), and the American Public Health Association have all adopted official positions of support for comprehensive sexuality education;[31–33] and

Whereas, The AMA has existing policy acknowledging the importance and public health benefit of sex education, including Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968; Health Information and Education H-170.986; and Comprehensive Health Education H-170.977, but falls short of underscoring the importance of comprehensive sex education in schools or advocating for actual implementation; and

Whereas, Lack of funding for comprehensive sex education programs means they are less likely to be taught; therefore be it

RESOLVED, That our American Medical Association amend Policy H-170.968, "Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools," by addition and deletion to read as follows:

> Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools, H-170.968
>
> (1) ~~Recognizes that the primary responsibility for family life education is in the home, and additionally~~ ~~s~~ Supports the concept of a ~~complementary~~ family life and sexuality education program in the schools at all levels, at local option and direction;
> (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms dental dams, and other barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ ~~gay, lesbian, and bisexual~~ youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i)

include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of ~~abstinence in~~ preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, ~~and also teach about~~ including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
(10) Encourages physicians and all interested parties to ~~conduct research and~~ develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.
(Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

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RELEVANT AMA POLICY

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968

(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with

young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.
Citation: CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16; Appended: Res. 401, A-16; Appended: Res. 414, A-18; Appended: Res. 428, A-18

Television Broadcast of Sexual Encounters and Public Health Awareness H-485.994
The AMA urges television broadcasters, producers, and sponsors to encourage education about safe sexual practices, including but not limited to condom use and abstinence, in television programming of sexual encounters, and to accurately represent the consequences of unsafe sex.
Citation: (Res. 421, I-91; Reaffirmed: CSA Rep. 3, A-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15)

Health Information and Education H-170.986
(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention,

and their development and maintenance should be promoted.
(2) Employers should provide and employees should participate in programs on health awareness, safety and the use of health care benefit packages.
(3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite.
(4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse.
(5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities.
(6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care.
(7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the health care delivery system to their patients and to the local community.
(8) Information on health and health care should be presented in an accurate and objective manner.
(9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.
(10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.
(11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs.
(12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services.
(13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs.
Citation: BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-07; Reaffirmation A-15; Reaffirmed: BOT Rep. 15, A-19

Comprehensive Health Education H-170.977
(1) Educational testing to confirm understanding of health education information should be encouraged. (2) The AMA accepts the CDC guidelines on comprehensive health education. The CDC defines its concept of comprehensive school health education as follows: (a) a documented, planned, and sequential program of health education for students in grades pre-kindergarten through 12; (b) a curriculum that addresses and integrates education about a range of categorical health problems and issues (e.g., human immunodeficiency virus (HIV) infection, drug misuse, drinking and driving, emotional health, environmental pollution) at developmentally appropriate ages; (c) activities to help young people develop the skills they will need to avoid: (i) behaviors that result in unintentional and intentional injuries; (ii) drug and alcohol misuse; (iii) tobacco use; (iv) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies; (v) imprudent dietary patterns; and (vi)

inadequate physical activity; (d) instruction provided for a prescribe amount of time at each grade level; (e) management and coordination in each school by an education professional trained to implement the program; (f) instruction from teachers who have been trained to teach the subject; (g) involvement of parents, health professionals, and other concerned community members; and (h) periodic evaluations, updating, and improvement.
Citation: BOT Rep. X, A-92; Modified: CME Rep. 2, A-03; Reaffirmation A-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: CSAPH Rep. 01, A-19

HIV/AIDS Education and Training H-20.904
(1) Public Information and Awareness Campaigns
Our AMA:
a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.
b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;
c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;
d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;
e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.
(2) HIV/AIDS Education in Schools
Our AMA:
a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;
b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools.
(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers
Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.
Citation: CSA Rep. 4, A-03; Appended: Res. 516, A-06; Modified: CSAPH 01, A-16; Reaffirmed: Res. 916, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(A-22)

Introduced by: Resident and Fellow Section

Subject: Improvement of Care and Resource Allocation for Homeless Persons in the Global Pandemic

Referred to: Reference Committee D

Whereas, The COVID-19 pandemic has shown the ability to shelter in place as a social determinant of health[1], and the reduction of homelessness should be a major focus of public health efforts within the United States[2]; and

Whereas, The high prevalence of chronic health conditions such as cardiac disease, pulmonary disease, liver disease, smoking and accelerated aging in the homeless population increase their risk for poor disease outcomes for SARS-CoV2[2,3]; and

Whereas, Homeless shelters and encampments are particularly susceptible to large outbreaks of SARS-CoV2[2], and the crowding in informal settlements make self-quarantine nearly impossible leading to increase likelihood of rapid infection spread[4]; and

Whereas, Interventions that are designed to house, space and treat homeless persons to allow for adequate ability for persons to socially distance and quarantine are first steps to begin addressing this issue[3]; and

Whereas, Implementing housing-first interventions for homeless persons improves their quality of life while also reducing ineffective public service spending[5]; and

Whereas, Healthcare spending has been found to be up to 3.3 times higher for homeless persons than the national average of Medicaid spending per enrollee[6], and the homelessness is linked to greater usage of acute hospital services[5]; and

Whereas Involvement in drugs and untreated mental illness, compounded with other negative life events, are social determinants that often lead to homelessness[5]; and

Whereas, Current AMA policy has not made any measurable changes within this public health crisis by virtue of being too broad, therefore necessary changes must be added to make specific, measurable and worthwhile changes to advocate for the health of individuals experiencing homelessness in the United States; therefore be it

RESOLVED, That our American Medical Association support training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties (New HOD Policy); and be it further

RESOLVED, That our AMA support the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals (New HOD Policy); and be it further

RESOLVED, That our AMA reaffirm existing policies H-160.903, “Eradicating Homelessness,” and H-345.975, “Maintaining Mental Health Services by States” (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm existing policy H-160.978, “The Mentally Ill Homeless,” with a title change “Housing Insecure Individuals with Mental Illness”. (Reaffirm HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

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RELEVANT AMA POLICY

Eradicating Homelessness H-160.903

Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians’ role therein, in addressing these needs;
(7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(9) (a) supports laws protecting the civil and human rights of individuals experiencing

homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
Citation: Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19;

The Mentally Ill Homeless H-160.978
(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population.
Citation: BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: BOT Rep. 16, A-19;

Maintaining Mental Health Services by States H-345.975
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.
Citation: (Res. 116, A-12; Reaffirmation A-15)

Multiple-Drug Resistant Tuberculosis - A Multifaceted Problem H-440.938
(1) Testing for tuberculous infection should be performed routinely on all HIV-infected patients, according to current recommendations from the U.S. Public Health Service.
(2) Testing for HIV infection should be routinely performed on all persons with active tuberculosis.
(3) Reporting of HIV infection and tuberculosis should be linked to enhance appropriate medical

management and epidemiologic surveillance.
(4) Aggressive contact tracing should be pursued for cases of active tuberculosis, especially if HIV-infected contacts or multiple-drug resistant tuberculosis strains have been involved.
(5) HIV-infected health care workers and their physicians must be aware of the high risk of clinical TB for persons whose immune systems are compromised, due to HIV or other causes. They should be carefully apprised of their risk, and the risks and benefits of their caring for persons with active TB or suspected TB should be carefully considered.
(6) HIV-infected and other immunocompromised patients should be sufficiently separated from tuberculosis patients and the air they breathe so that transmission of infection is unlikely.
(7) All health care workers should have a tuberculin skin test upon employment, with the frequency of retesting determined by the prevalence of the disease in the community. Individuals with a positive skin test should be evaluated and managed according to current public health service recommendations.
(8) Health care facilities that treat patients with tuberculosis should rigorously adhere to published public health service guidelines for preventing the nosocomial transmission of tuberculosis.
(9) Adequate and safe facilities must be available for the care of patients with tuberculosis; in some areas this may necessitate the establishment of sanitariums or other regional centers of excellence in tuberculosis treatment.
(10) Clinical tuberculosis laboratories should develop the capability of reliably performing or having reliably performed for them rapid identification and drug susceptibility tests for tuberculosis.
(11) Routinely, drug susceptibility tests should be performed on isolates from patients with active tuberculosis as soon as possible.
(12) A program of directly observed therapy for tuberculosis should be implemented when patient compliance is a problem.
(13) The AMA should enlist the aid of the Pharmaceutical Research and Manufacturers of America (PhRMA) in encouraging manufacturers to develop new drugs and vaccines for tuberculosis.
(14) The federal government should increase funding significantly for tuberculosis control and research to curtail the further spread of tuberculosis and encourage development of new and effective diagnostics, drug therapies, and vaccines.
(15) The special attention of physicians, public health authorities, and funding sources should be directed toward high risk and high incidence populations such as the homeless, immigrants, minorities, health care workers in high risk environments, prisoners, children, adolescents, and pregnant women.
(16) The AMA will develop educational materials for physicians that will include but not be limited to the subtleties of testing for TB in HIV-infected individuals; potential risk to HIV-infected individuals exposed to infectious diseases, including TB; and other issues identified in this report.
(17) The AMA encourages physicians to remain informed about advances in the treatment of tuberculosis, including the availability of combination forms of drugs, that may reduce the emergence of drug-resistant strains.
Citation: (BOT Rep. OO, A-92; Sub. Res. 505, I-94; Reaffirmed and Modified: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(A-22)

Introduced by: Obesity Medicine Association, Colorado, Arizona

Subject: Creation of an Obesity Task Force

Referred to: Reference Committee D

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1 Whereas, Obesity has been recognized by our AMA as a disease[1]; and
2
3 Whereas, Obesity is preventable and effective treatments are available; and
4
5 Whereas, A top strategic objective of our AMA is to improve health outcomes with regards to
6 type two diabetes and hypertension;[2] and
7
8 Whereas, Obesity rates continue to increase and obesity (BMI 30 or more) currently affects 40%
9 of Americans and overweight/pre-obesity (BMI 25 - 29.9) affects 32% of Americans[3]; and
10
11 Whereas, Obesity is currently estimated to kill 320,000 Americans and cost 1.72 trillion dollars
12 (9.3% of GDP) per year[4]; and
13
14 Whereas, People with obesity are at a higher risk for suffering severe complications from
15 COVID-19 including ICU admissions, mechanical ventilation and death[5]; and
16
17 Whereas, "The prevalence of adult obesity and severe obesity will continue to increase
18 nationwide, with large disparities across states and demographic subgroups;"[6] and
19
20 Whereas, Obesity rates in children ages 2-19 continue to increase and obesity is currently
21 estimated to affect 19% of children[7]; and
22
23 Whereas, The Framingham Heart Study estimated that excess body weight (including
24 overweight and obesity), accounted for approximately 26 percent of cases of hypertension in
25 men and 28 percent in women, and for approximately 23 percent of cases of coronary heart
26 disease in men and 15 percent in women[8]; and
27
28 Whereas, While the Affordable Care Act requires payment of preventive health care services
29 rated by the United States Preventive Task Force Services (USPSTF) with an "A" or "B"
30 recommendation, and the USPSTF recommends obesity screening and counseling services

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[1] AMA policy H-440.842
[2] https://www.ama-assn.org/delivering-care/public-health/about-improving-health-outcomes
[3] Cheryl D. Fryar; et al. (September 2018). "Prevalence of Overweight, Obesity, and Severe Obesity Among Adults Aged 20 and Over: United States, 1960–1962 Through 2015–2016" (PDF). Health E-Stats. National Center for Health Statistics, Division of Health Interview Statistics. Retrieved December 26, 2018.
[4] https://milkeninstitute.org/sites/default/files/reports-pdf/Mi-Americas-Obesity-Crisis-WEB.pdf accessed 11/14/2019
[5] Kompaniyets L, Goodman AB, Belay B, et al. Body mass index and risk for COVID-19-related hospitalization, intensive care unit admission, invasive mechanical ventilation, and death - United States, March - December 2020. MMWR Morb Mortal Wkly Rep. 2021;70(10):355-361.
[6] N Engl J Med 2019; 381:2440-2450. DOI: 10.1056/NEJMsa1909301
[7] https://www.cdc.gov/obesity/data/childhood.html accessed 11/18/2019
[8] https://www.obesityaction.org/community/article-library/hypertension-and-obesity-how-weight-loss-affects-hypertension/ accessed 11/18/2019

(evidence grade "B"), 24 states currently have general exclusions for weight/obesity management services and make no mention of obesity screening and counseling services.[9] This represents discriminatory behavior, which is in direct contradiction to established AMA policy: "Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act."[10]; and

Whereas, Obesity disproportionately affects women and minorities[11,12,13]; and

Whereas, According to the CDC Maternal morbidity and mortality rates are indirect measure of the strength of our healthcare; and women with obesity are at increased risk for cardiac dysfunction, proteinuria, sleep apnea, nonalcoholic fatty liver disease, gestational diabetes mellitus, and preeclampsia[14] and pre-pregnancy obesity is associated with infertility, stillbirth, early termination of breastfeeding, postpartum anemia, and depression. Further, long-term risks for the infants of women with obesity include an increased risk of metabolic syndrome and childhood obesity;[15] and

Whereas, In a nationally representative sample of US adults, the prevalence of diabetes increases with increasing weight classes. Nearly one fourth of adults with diabetes have poor glycemic control and nearly half of adults with diabetes have obesity, suggesting that weight loss is an important intervention to reduce the impact of diabetes on the health care system[16]; and

Whereas, It is estimated that the prevalence of diabetes will increase by 54% to more than 54.9 million Americans between 2015 and 2030; annual deaths attributed to diabetes will climb by 38% to 385,800; and total annual medical and societal costs related to diabetes will increase 53% to more than $622 billion by 2030[17]; and

Whereas, Consistent with the AMA's improving health outcomes strategic plan initiative, "The best solution for turning around the diabetes epidemic is preventing prediabetes and its progression to diabetes in the first place. Achieving such an outcome calls for addressing underlying societal risk factors that can contribute to unhealthy lifestyles and would require a "population-wide" approach that addresses health promotion, obesity prevention, and creates a physical, cultural, and psychological environment that supports healthy living naturally. This outcome could not be achieved by individual health providers and patients alone, but requires integrated systems of care incentivized for desired health outcomes. It also would require a political will for effective policies and commitment of the public at all levels"[18]; and

Whereas, In spite of AMA policy calling on our AMA to work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions), coverage of these services remains

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[9] https://www.cms.gov/cciio/resources/data-resources/ehb.html
[10] Resolution 814, i16 – H-185.925
[11] CDC, http://www.cdc.gov/nchs/data/hestat/obesity_adult_11_12/obesity_adult_11_12.htm accessed 11/14/2016
[12] https://www.cdc.gov/pcd/issues/2019/18_0579.htm accessed 3/10/2022
[13] Flegal KM, Kruszon-Moran D, Carroll MD, Fryar CD, Ogden CL. Trends in Obesity Among Adults in the United States, 2005 to 2014. JAMA. 2016;315(21):2284-2291. doi:10.1001/jama.2016.6458
[14] American College of Obstetricians and Gynecologists' Committee on Practice Bulletins–Obstetrics. Obesity in Pregnancy: ACOG Practice Bulletin, Number 230. Obstet Gynecol. 2021 Jun 1;137(6):e128-e144.
[15] Boney CM , Verma A , Tucker R , Vohr BR . Metabolic syndrome in childhood: association with birth weight, maternal obesity, and gestational diabetes mellitus . Pediatrics 2005 ; 115 : e290 – 6
[16] https://www.ncbi.nlm.nih.gov/pubmed/21128002 accessed 11/18/2019
[17] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5278808/ accessed 3/10/2022
[18] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5278808/

inconsistent, with Medicare still not allowing payment for behavioral treatment outside of the primary care setting, or for anti-obesity pharmacotherapy[19]; and

Whereas, While 85% of individuals affected by type 2 diabetes receive pharmacotherapy, only ~2% receive obesity pharmacotherapy[20] and only ~1% receive metabolic and bariatric surgery[21], both modalities that can improve health outcomes including prediabetes, diabetes and hypertension and deserve a broader multi-stakeholder strategy; and

Whereas, Simply telling patients affected by obesity to "eat less, move more," has not worked and has been shown not to result in long-term sustained weight loss over 85% of the time because CNS pathways sense changes in weight and body energy stores and exert opposing effects on energy balance to promote homeostasis[22,23,24]; and

Whereas, A recent AMA report found that obesity education remains inadequate at medical school and residency programs[25]; and

Whereas, "Low levels of emotional rapport in primary care visits with patients with overweight and obesity may weaken the patient-physician relationship, diminish patients' adherence to recommendations, and decrease the effectiveness of behavior change counseling," leading to increases in physician burnout[26]; and

Whereas, Our AMA is in a position to influence public policies around obesity ranging from public awareness and physician education to public policy around nutrition and insurance coverage of evidence-based obesity prevention and treatment services; and

Whereas, In spite of the numerous policies our AMA has adopted regarding obesity, education remains sparse[27], coverage for evidence-based services remains inconsistent, and current efforts at prevention and treatment remain largely ineffective; and

Whereas, An Obesity Caucus, formed in 2015, has been growing and attracting multiple state and specialty societies; and

Whereas, Our AMA has demonstrated that through creation of a task force, we can successfully address health epidemics including the tobacco and opioid epidemics; therefore be it

RESOLVED, That our American Medical Association create an obesity task force to evaluate and disseminate relevant scientific evidence to healthcare clinicians, other providers and the public (Directive to Take Action); and be it further

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[19] Policy D-440.954, AMA a18
[20] Thomas CE, Mauer EA, Shukla AP, Rathi S, Aronne LJ. Low adoption of weight loss medications: a comparison of prescribing patterns of antiobesity pharmacotherapies and SGLT2s. Obesity (Silver Spring). 2016; 24(9):1955–61.
[21] https://www.asmbs.org
[22] Chaput JP et al. Obes Rev. 2012;13:681-691.
[23] NHLBI. 2012. www.nhlbi.gov/health/health-topics/topics/obe/causes#. Accessed May 23rd, 2017.
[24] Schwartz MW et al. Diabetes. 2003;52:232-238.
[25] CME report 3, AMA a-17
[26] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3694993/ Accessed 11/19/2019
[27] Mastrocola MR, et al. Int J Obes (Lond). 2019. (https://www.ncbi.nlm.nih.gov/m/pubmed/31551484/?i=4&from=stanford%20fc#) Accessed 11/21/2019

RESOLVED, That the obesity task force address issues including but not limited to:

- Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.
- Advocacy efforts at the state and federal level to impact the disease obesity.
- Health disparities, stigma and bias affecting people with obesity.
- Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
- Increasing obesity rates in children, adolescents and adults.
- Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 04/21/22

RELEVANT AMA POLICY

Recognition of Obesity as a Disease H-440.842
Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.
Citation: (Res. 420, A-13)

Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act H-185.925
1. Our AMA supports improvements to the essential health benefits benchmark plan selection process to ensure limits and exclusions do not impede access to health care and coverage.
2. Our AMA encourages federal regulators to develop policy to prohibit essential health benefits substitutions that do not exist in a state's benchmark plan and the selective use of exclusions or arbitrary limits that prevent high-cost claims or that encourage high-cost enrollees to drop coverage.
3. Our AMA encourages federal regulators to review current plans for discriminatory exclusions and submit any specific incidents of discrimination through an administrative complaint to Office for Civil Rights.
Citation: Res. 814, I-16;

Addressing Obesity D-440.954
1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3.Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.
BOT Rep. 11, I-06 Reaffirmation A-13 Appended: Sub. Res. 111, A-14 Modified: Sub. Res. 811, I-14 Appended: Res. 201, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(A-22)

Introduced by: Oklahoma

Subject: School Resource Officer Violence De-Escalation Training and Certification

Referred to: Reference Committee D

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1 Whereas, A school resource officer (SRO), by federal definition, is a career law enforcement
2 officer with sworn authority who is deployed by an employing police department or agency in a
3 community-oriented policing assignment to work in collaboration with one or more schools(1);
4 and
5
6 Whereas, National Association of School Resource Officers recommends that agencies select
7 officers carefully for SRO assignments and that officers receive at least 40 hours of specialized
8 training in school policing before being assigned(1); and
9
10 Whereas, The Oklahoma Association of School Resource Officers report most but not all SRO
11 in schools throughout Oklahoma receive this nationally-recognized, basic and advanced SRO
12 training(2); and
13
14 Whereas, Widespread protests against police brutality and racial injustice over several years
15 have spurred districts across the nation to debate whether to keep police officers in schools(3);
16 therefore be it
17
18 RESOLVED, That our American Medical Association highly recommend mandatory conflict
19 de-escalation training for all school resource officers (New HOD Policy); and be it further
20
21 RESOLVED, That our AMA actively advocate to the National Association of School Resource
22 Officers to develop a program for certification of School Resource Officers including but not
23 limited to violence de-escalation training requirements, expiration date, renewal continuing
24 education requirements and a revocation procedure in the rare event of misconduct. (Directive
25 to Take Action)

REFERENCES
1. https://www.nasro.org/faq/
2. https://m.facebook.com/OklahomaAssociationOfSchoolResourceOfficers/
3. https://www.google.com/amp/s/oklahoman.com/article/5666711/okc-board-approves-2-million-contract-for-school-resource-officers/amp

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/26/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(A-22)

Introduced by: Oklahoma

Subject: Tobacco Control

Referred to: Reference Committee D

Whereas, Tobacco remains the leading cause of preventable disease in America, killing more than 480,000 Americans each year; and

Whereas, 16 million Americans are living with a tobacco-related disease; and

Whereas, The tobacco companies have conducted an organized conspiracy to commit fraud in violation of the federal Racketeer Influenced and Corrupt Organization (RICO) Act; and

Whereas, 2020 should be the year that health of our citizens is prioritized over the tobacco industry; and

Whereas, A smoke-free work environment should be afforded to all U.S. citizens; and

Whereas, Secondhand smoke is a serious health hazard causing, or making worse, many diseases and conditions, including lung cancer, heart disease, stroke, and asthma; and

Whereas, The U.S. Surgeon General has concluded there is no safe level of exposure to secondhand smoke; and

Whereas, Oklahoma is one of 22 states that has failed to pass comprehensive smoke-free laws; and

Whereas, Many workplaces like the hospitality industry (i.e., restaurants, bars, and gaming establishments) in Oklahoma are often exposed to secondhand smoke daily; and

Whereas, By making white-collar workplaces smoke free while allowing blue-collar workplaces to continue to expose people to hazardous air, our current policies are widening inequalities in health; and

Whereas, If 100% of workplaces were covered by smoke free policies, health disparities would be significantly reduced; therefore be it

RESOLVED, That American Medical Association policy H-490.913, “Smoke-Free and Vape-Free Environments and Workplaces,” be amended by addition and deletion to read as follows:

> On the issue of the health effects of environmental tobacco smoke (ETS), passive smoke, and vape aerosol exposure in the workplace and other public facilities, our AMA: (1)(a) supports classification of ETS as a known human carcinogen, and (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease, and (c) encourages physicians and medical

societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry, and and (d) encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government, and (2) (a) honors companies and governmental workplaces that go smoke-free and vape-free, and (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking and vaping in the workplace, and (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces, and and (d) will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws. (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free and vape-free schools and eliminating smoking and vaping in public places and businesses and on any public transportation, and (ii) enlist the aid of county medical societies in local anti-smoking and anti-vaping campaigns, and and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures, and (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment, and (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children, and (d) encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others, and (e) urges eliminating cigarette, pipe and cigar smoking and vaping in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking inhalation, and (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking or non-vaping ordinance is introduced and to become directly involved in community tobacco control activities, and and (g) will report annually to its membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia, and (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts, and (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools, and (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities, and

(7) ~~encourages and supports~~ collaborates with local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos, and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues. (Modify Current HOD Policy)

REFERENCES
https://www.lung.org/our-initiatives/tobacco/reports-resources/sotc/
https://no-smoke.org/wp-content/uploads/pdf/BridgingtheGap-ExecutiveSummary.pdf

Fiscal Note: Minimal - less than $1,000

Received: 04/26/22

RELEVANT AMA POLICY

Smoke-Free and Vape-Free Environments and Workplaces H-490.913
On the issue of the health effects of environmental tobacco smoke (ETS), passive smoke, and vape aerosol exposure in the workplace and other public facilities, our AMA: (1)(a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free and vape-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking and vaping in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws. (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free and vape-free schools and eliminating smoking and vaping in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking and anti-vaping campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children; (d) encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe and cigar smoking and vaping in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking inhalation; (f) urges state and county medical societies and local health professionals to be especially

prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking or non-vaping ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia; (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and (7) encourages and supports local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues.
CSA Rep. 3, A-04; Appended: Sub. Res. 426, A-04; Modified: CSAPH Rep. 1, I-07; Reaffirmation I-14; Reaffirmation I-15; Modified: Res. 902, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(A-22)

Introduced by: Oklahoma

Subject: Lung Cancer Screening Awareness

Referred to: Reference Committee D

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1 Whereas, Oklahoma health outcomes are poor and rank low on a yearly basis; and
2
3 Whereas, Lung cancer is the number one cause of cancer-related death in Oklahoma, U.S., and
4 the world, and is more deadly than the next major causes combined: Breast, prostate, colon(1),
5 and
6
7 Whereas, According to the American Lung Association State of Lung Cancer Report, most lung
8 cancer cases are diagnosed at later stages when the cancer has spread to other organs,
9 treatment options are less likely to be curative, and survival is lower(2); and
10
11 Whereas, The rationale for lung cancer screening is that it is prevalent, detectable, non-invasive
12 at an early stage, outcome depends on stage, and stage is a function of time(3); and
13
14 Whereas, Lung cancer screening with low-dose CT scans has been recommended for those at
15 high risk since 2013 but only 4.2 percent of those eligible were screened in 2018(2); and
16
17 Whereas, Lung cancer screening with low-dose CT scans has been shown to decrease
18 mortality by 20%(4); and
19
20 Whereas, 12.7% adults aged 55–80 years met the United States Preventive Services Task
21 Force (USPSTF) criteria for lung cancer screening. Among those meeting these criteria, only
22 12.5% reported they had received a CT scan to screen for lung cancer in the last 12 months(1);
23 and
24
25 Whereas, Oklahoma was one of 31 states that has improved access to screening by covering it
26 through its fee-for-service Medicaid program as of January 2019. The program used
27 recommended guidelines for determining eligibility but it requires prior authorization(2);
28 therefore be it
29
30 RESOLVED, That our American Medical Association empower the American public with
31 knowledge through an education campaign to raise awareness of lung cancer screening with
32 low-dose CT scans in high-risk patients to improve screening rates and decrease the leading
33 cause of cancer death in the United States. (Directive to Take Action)

REFERENCES:
(1) https://www.cdc.gov/mmwr/volumes/69/wr/mm6908a1.htm?s_cid=mm6908a1_w
(2) https://www.lung.org/assets/documents/research/ALA-SOLC-2019-Key-Findings.pdf
(3) https://www.ncbi.nlm.nih.gov/m/pubmed/22031728/
(4) https://www.nejm.org/doi/full/10.1056/NEJMoa1911793

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 04/26/22

Evidence-based review:

https://www.nejm.org/doi/full/10.1056/NEJMoa1102873

8/4/2011, NEJM
Screening with the use of low-dose CT reduces mortality from lung cancer. (Funded by the National Cancer Institute; National Lung Screening Trial ClinicalTrials.gov number, **NCT00047385.**

https://www.nejm.org/doi/full/10.1056/NEJMoa1911793

2/06/2020 NEJM
In this trial involving high-risk persons, lung-cancer mortality was significantly lower among those who underwent volume CT screening than among those who underwent no screening. There were low rates of follow-up procedures for results suggestive of lung cancer.

https://www.cdc.gov/mmwr/volumes/69/wr/mm6908a1.htm?s_cid=mm6908a1_w
2.28/2020 MMWR

What is already known about this topic?
The U.S. Preventive Services Task Force (USPSTF) recommends annual lung cancer screening for adults aged 55–80 years who have a ≥30 pack-year cigarette smoking history and currently smoke or have quit <15 years ago.

What is added by this report?
In 10 states, one in eight persons aged 55–80 years met USPSTF criteria, and, among those meeting USPSTF criteria, only one in eight reported a lung cancer screening exam in the last 12 months.

What are the implications for public health practice?
Public health initiatives to prevent cigarette smoking, increase smoking cessation, and increase recommended lung cancer screening could help reduce lung cancer mortality.

https://pubmed.ncbi.nlm.nih.gov/32001154/
Clinical Lung Cancer, 5/2020
Lung cancer screening remains heavily underutilized despite guideline recommendation since 2013, insurance coverage, and its potential to prevent thousands of lung cancer deaths annually.

file:///C:/Users/wjenkins/Downloads/ritzwoller_2021_oi_210815_1633035210.98986.pdf

JAMA Network Open, 10/12/2021
This cohort study suggests that, in diverse health care systems, adopting the 2021 USPSTF recommendations will increase the number of women, racial and ethnic minority groups, and individuals with lower SES who are eligible for lung cancer screening, thus helping to minimize the barriers to screening access for individuals with high risk for lung cancer.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(A-22)

Introduced by: Illinois

Subject: Advocating for the Utilization of Police and Mental Health Care Co-Response Teams for 911 Mental Health Emergency Calls

Referred to: Reference Committee D

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1 Whereas, Individuals with mental health illnesses are overrepresented in the criminal justice
2 system[1]; and
3
4 Whereas, Researchers estimate that 7-10% of all police interactions involve mental health crisis
5 assistance[2]; and
6
7 Whereas, The number of violent incidents that occur during mental health-related calls might
8 have been mitigated with the assistance of medical professionals; and
9
10 Whereas, Police officers are not universally trained in mental health crisis control; and
11
12 Whereas, Many police departments have tried to address police mental health training through
13 crisis intervention team (CIT) models where police are trained in de-escalation tactics and
14 provided with resources to refer individuals to mental health services rather than criminal justice
15 services[3,4]; and
16
17 Whereas, Researchers have demonstrated that even police officers trained in CIT models were
18 only able to recognize half as many cases of mental health illness as clinically trained graduate
19 students[5]; and
20
21 Whereas, Qualitative analysis of officers in the Chicago Police Department have demonstrated
22 that officers are frustrated with their inability to effect long-term change for people in mental
23 health-related calls due to the constraints of the current system[6]; and
24
25 Whereas, The Illinois Criminal Justice Information Authority found that nearly 70% of Illinois
26 police departments consider mental health issues as one of the top issues for their department[3];
27 and
28
29 Whereas, The number of mental health-related police detentions and hospitalizations are
30 greatly reduced in mental health and police co-responder models compared to police-only
31 models[4,7,8]; and
32
33 Whereas, The average cost per mental health crisis is lower in existing street triage models
34 compared to a police-only response[4,9,10]; and
35
36 Whereas, Major cities including Chicago and New York City are launching co-responder
37 programs so that police officers are paired with a healthcare professional when responding to
38 mental health crisis calls; therefore be it

1 RESOLVED, That our American Medical Association support efforts to increase the use of
2 co-response (police and mental health worker) teams for non-violent mental health-related 911
3 calls. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/02/22

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RELEVANT AMA POLICY

Increasing Detection of Mental Illness and Encouraging Education D-345.994

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.
2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.
Citation: Res. 412, A-06; Appended: Res. 907, I-12; Reaffirmed in lieu of: Res. 001, I-16;

Maintaining Mental Health Services by States H-345.975

Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.

Citation: (Res. 116, A-12; Reaffirmation A-15)

Mental Health Crisis Interventions H-345.972
Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; and (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities.
Citation: Res. 923, I-15; Appended: Res. 220, I-18; Reaffirmed: CSAPH Rep. 2, A-21; Reaffirmed: BOT Rep. 2, I-21;

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955
Our AMA:
1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.
Citation: Res. 406, A-16; Modified: BOT Rep. 28, A-18; Reaffirmed: BOT Rep. 2, I-21;

Prevention of Unnecessary Hospitalization and Jail Confinement of the Mentally Ill H-345.995
Our AMA urges physicians to become more involved in pre-crisis intervention, treatment and integration of chronic mentally ill patients into the community in order to prevent unnecessary hospitalization or jail confinement.
Citation: (Res. 16, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmation A-15)

Reference Committee E

CSAPH Report(s)

03 Correcting Policy H-120.958

Resolution(s)

501 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use
502 Ensuring Correct Drug Dispensing
503 Pharmacy Benefit Managers and Drug Shortages
504 Scientific Studies Which Support Legislative Agendas
505 CBD Oil Use and the Marketing of CBD Oil
506 Drug Manufacturing Safety
507 Federal Initiative to Treat Cannabis Dependence
508 Supplemental Resources for Inflight Medical Kit
509 Regulation and Control of Self-Service Labs
510 Evidence-Based Deferral Periods for MSM Cornea and Tissue Donors
511 Over the Counter (OTC) Hormonal Birth Control
512 Scheduling and Banning the Sale of Tianeptine in the United States
513 Education for Patients on Opiate Replacement Therapy
514 Oppose Petition to the DEA and FDA on Gabapentin
515 Reducing Polypharmacy as a Significant Contributor to Senior Morbidity

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-A-22

Subject: Correcting Policy H-120.958

Presented by: Alexander Ding, MD, MS, MBA, Chair

Referred to: Reference Committee E

At the June 2020 Special Meeting of the House of Delegates, the Council on Science and Public Health's sunset report recommended that Policy H-120.958, "Supporting Safe Medical Products as a Priority Public Health Initiative" be retained in part and made the changes indicated here:

> Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names;
> (2) continue participation ~~i~~on the ~~National Patient Safety Foundation's efforts to advance the science of safety in the medication use process and likewise work with the~~ National Coordinating Council for Medication Error Reporting and Prevention;
> (3) support the FDA's Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events;
> (4) vigorously work to support and encourage efforts to create and expeditiously implement a national ~~machine-readable~~ coding system for prescription medicine packaging in an effort to improve patient safety; and
> (5) ~~participate in and report on the work of the Healthy People 2010 initiative in the area of safe medical products especially as it relates to existing AMA policy; and~~
> (6) seek opportunities to work collaboratively with other stakeholders ~~within the Medicine-Public Health initiative (H-440.991) and with the Food and Drug Administration (FDA), National Institutes of Health (NIH), United States Pharmacopoeia (USP) and Centers for Disease Control and Prevention (CDC) the Agency for Health Care Policy and Research (AHCPR) and the Centers for Medicare & Medicaid Services (CMS)~~ to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety.

The recommended changes were adopted, and the revised policy was recorded in PolicyFinder.

At the November 2021 Special Meeting, CSAPH Report 4 proposed changes to Policy H-120.958 but erroneously proposed those changes to the version of the policy as it had existed before 2020's sunset report. The recommendation found in CSAPH Report 4-N-21 reads as follows:

> Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names;
> (2) continue participation in ~~the National Patient Safety Foundation's~~ efforts to advance the science of safety in the medication use process, including ~~and likewise~~ work with the National Coordinating Council for Medication Error Reporting and Prevention;

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(3) support the FDA's Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events;
(4) vigorously work to support the Drug Supply Chain and Security Act (DSCSA, Public Law 113-54), including provisions on product identification and verification, data sharing, detection and response, ~~and encourage efforts to create and expeditiously implement a national machine-readable coding system for prescription medicine packaging~~ in an effort to improve patient safety;
(5) participate in and report on the work of the Healthy People ~~2010~~ 2030 initiative in the area of safe medical products especially as it relates to existing AMA policy; and
(6) seek opportunities to work collaboratively within the Medicine-Public Health initiative (H-440.991) and with the Food and Drug Administration (FDA), National Institutes of Health (NIH), United States Pharmacopoeia (USP) and Centers for Disease Control and Prevention (CDC) the Agency for ~~Health Care Policy and Research (AHCPR)~~ Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety.

We recognize that the starting point for any changes to policy must be the current version of the policy as found in PolicyFinder, which is the June 2020 revision. That policy reads as follows:

Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names; (2) continue participation on the National Coordinating Council for Medication Error Reporting and Prevention; (3) support the FDA's Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events; (4) vigorously work to support and encourage efforts to create and expeditiously implement a national coding system for prescription medicine packaging in an effort to improve patient safety; and (5) seek opportunities to work collaboratively with other stakeholders to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety.

CONCLUSION

The Council on Science and Public Health recommends reconciliation of the amendments to Policy H-120.958, "Supporting Safe Medical Products as a Priority Public Health Initiative," as outlined below. This language ensures that AMA policy supports the Drug Supply Chain and Security Act as addressed in the Council's pharmacovigilance report, acknowledges our willingness to engage with Healthy People 2030 on safe medical products, and streamlines the various federal agencies and stakeholders engaged in this important work.

RECOMMENDATION

Your Council recommends that the following be adopted and the remainder of this report be filed.

1. That Policy H-120.958, "Supporting Safe Medical Products as a Priority Public Health Initiative," be amended by addition and deletion to read as follows:

   Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names; (2) continue participation in efforts to advance the science of safety in the

medication use process, including work with ~~on~~ the National Coordinating Council for Medication Error Reporting and Prevention; (3) support the FDA's Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events; (4) vigorously work to support the Drug Supply Chain and Security Act (DSCSA, Public Law 113-54), including provisions on product identification and verification, data sharing, detection and response, ~~and encourage efforts to create and expeditiously implement a national coding system for prescription medicine packaging~~ in an effort to improve patient safety; (5) participate in the work of the Healthy People 2030 initiative in the area of safe medical products especially as it relates to existing AMA policy and (~~5~~6) seek opportunities to work collaboratively with other stakeholders to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety.

Fiscal Note: $1000

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 501
(A-22)

Introduced by: Young Physicians Section

Subject: Marketing Guardrails for the "Over-Medicalization" of Cannabis Use

Referred to: Reference Committee E

Whereas, The cannabis-legalization movement has swept the country; and

Whereas, In many states, "medical cannabis" and "medical marijuana" laws have put physicians in the uncomfortable position of being asked to prescribe cannabis for questionable medical indications; and

Whereas, In states where medical cannabis has been legalized, marketing for cannabis for "all your ills" has become excessive; and

Whereas, Emerging research in Colorado has shown that "marijuana use during pregnancy, concerns related to marijuana in homes with children, and adolescent use should continue to guide public health education and prevention efforts:

- The percentage of women who use marijuana in pregnancy … is higher among younger women, women with less education, and women with unintended pregnancies. Marijuana exposure in pregnancy is associated with decreased cognitive function and attention problems in childhood;

- Unintentional marijuana consumption among children under age 9 continues a slow upward trend, as do emergency visits due to marijuana. Additionally, an estimated 23,000 homes with children in Colorado have marijuana stored potentially unsafely. Marijuana exposures in children can lead to significant clinical effects that require medical attention;" [1] and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) warns that women who are pregnant or contemplating pregnancy should be encouraged to discontinue marijuana use, because of concerns regarding impaired neurodevelopment;" [2] and

Whereas, Infants exposed to marijuana during pregnancy had a decrease in birth weight, preterm delivery, and long-term adverse neurodevelopmental effects;[3] and

Whereas, In some states, women who are positive for cannabis are restricted from providing breastmilk to preterm babies in the neonatal intensive care unit; and

Whereas, There may be a correlation between heavy cannabis use during adolescence and neuropsychiatric diseases such as schizophrenia;[4] and

Whereas, The U.S. Surgeon General has issued a warning about “Marijuana Use and the Developing Brain;”[5,6] and

Whereas, ACOG has issued a statement discouraging obstetrician–gynecologists from prescribing or suggesting the use of marijuana for medicinal purposes during preconception, pregnancy, and lactation;[2] and

Whereas, Despite such warnings, cannabis is promoted as a treatment for hyperemesis with many pregnant women being marketed a neuroactive drug during critical developmental periods of the embryo and fetus;[7] and

Whereas, Two-thirds of Colorado’s cannabis dispensaries recommend marijuana for first trimester nausea although chronic cannabis use is actually associated with nausea and vomiting, which leads to emergency department visits;"[1] and

Whereas, Marketing cannabis to vulnerable populations like pregnant women and adolescents can have long-term effects for population health; and

Whereas, As an example, the targeted marketing of menthol cigarettes to African-Americans has led to in 85% of Black smokers using menthol cigarettes compared to 29% of White smokers and contributing to health disparities;[8] and

Whereas, A report by a committee of the Food and Drug Administration concluded that if menthol cigarettes had been removed from the marketplace in 2010, then (a) by 2020, roughly 17,000 premature deaths would have been avoided and about 2.3 million people would not have started smoking;[8] and

Whereas, Inadequate information about the potential dangers/harms of cannabis (especially among vulnerable populations) is available, especially amid the storm of pro-cannabis marketing from that industry; and

Whereas, This results in the lay public considering cannabis to be as safe as Tylenol, or carrots; and

Whereas, Regulation of supplements continues to be highly flawed; and

Whereas, There are a small number of cannabinoid products (such as marinol) which are indeed FDA-approved for specific indications; and

Whereas, There appears to be a need for “guardrails” for the marketing of cannabis, especially to protect vulnerable populations; and

Whereas, AMA has established policy to seek more data on cannabis, but in the meantime, cannabis and cannabinoid products are rapidly becoming the “snake oil” of our time; therefore be it

RESOLVED, That our American Medical Association send a formal letter to the Food and Drug Administration and Federal Trade Commission requesting more direct oversight of the marketing of cannabis for medical use. (Directive to Take Action)

Fiscal note: Minimal - less than $1,000

Date Received: 03/17/22

References

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RELEVANT AMA POLICY

Cannabis Warnings for Pregnant and Breastfeeding Women H-95.936

Our AMA advocates for regulations requiring point-of-sale warnings and product labeling for cannabis and cannabis-based products regarding the potential dangers of use during pregnancy and breastfeeding wherever these products are sold or distributed.
Citation: Res. 922, I-15; Reaffirmed: CSAPH Rep. 05, I-17;

Taxes on Cannabis Products H-95.923

Our AMA encourages states and territories to allocate a substantial portion of their cannabis tax revenue for public health purposes, including: substance abuse prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts.
Citation: CSAPH Rep. 05, I-17;

Cannabis and Cannabinoid Research H-95.952

1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.
2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.
3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be

supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.
4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.
5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.
6. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.
7. Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.
Citation: CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01; Modified: CSAPH Rep. 3, I-09; Modified in lieu of Res. 902, I-10; Reaffirmed in lieu of Res. 523, A-11; Reaffirmed in lieu of Res. 202, I-12; Reaffirmed: CSAPH Rep. 2, I-13; Modified: CSAPH Rep. 05, I-17; Reaffirmed in lieu of: Res. 434, A-19; Appended: Res. 913, I-19;

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924
Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.
Citation: CSAPH Rep. 05, I-17; Appended: Res. 913, I-19; Modified: CSAPH Rep. 4, I-20;

Cannabis Legalization for Medicinal Use D-95.969

Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; (6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians; and (7) encourages hospitals and health systems to: (a) not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use; and (b) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.
Citation: CSAPH Rep. 05, I-17; Appended: Res. 211, A-18; Appended: CSAPH Rep. 3, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 502
(A-22)

Introduced by: New York

Subject: Ensuring Correct Drug Dispensing

Referred to: Reference Committee E

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

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

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

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

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

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

RESOLVED, That our American Medical Association request that the United States Food and Drug Administration work with the pharmaceutical and pharmacy industries to facilitate the ability of pharmacies to ensure that a color photo of a prescribed medication and its dosage is attached to the sales receipt to ensure that the drug dispensed is that which has been prescribed. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 03/22/22

RELEVANT AMA POLICY

Epidemiology of Drug Errors H-120.963
The AMA will continue its collaborations with the Food and Drug Administration and the US Pharmacopoeial Convention, Inc., along with its own ongoing initiatives, to identify and eliminate causes of medication errors.
Citation: Sub. Res. 519, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16

Supporting Safe Medical Products as a Priority Public Health Initiative H-120.958
Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names; (2) continue participation on the National Coordinating Council for Medication Error Reporting and Prevention; (3) support the FDA's Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events; (4) vigorously work to support and encourage efforts to create and expeditiously implement a national coding system for prescription medicine packaging in an effort to improve patient safety; and (5) seek opportunities to work collaboratively with other stakeholders to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety.
Citation: Res. 416, A-99; Appended: Res. 504, I-01; Reaffirmation A-10; Modified: CSAPH Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 503
(A-22)

Introduced by: New York

Subject: Pharmacy Benefit Managers and Drug Shortages

Referred to: Reference Committee E

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1 Whereas, Pharmacy Benefit Managers (PBMs) are poorly regulated entities which act as
2 middlemen between health plans, pharmacies and drug manufacturers; and
3
4 Whereas, They have been associated with adverse business practices including opaque
5 operations ‘spread pricing’, and skyrocketing drug costs; and
6
7 Whereas, PBM’s play an important part in the pharmaceutical supply chain--sometimes
8 bankrupting pharmacies and making (and breaking) markets for pharmaceutical agents; and
9
10 Whereas, Drug manufacturers are legally obligated to report existing or pending drug shortages
11 to the Food and Drug Administration, that requirement extends only to drug supply disruptions,
12 not detailed information on their supply chain, in which PBMs play a key role; and
13
14 Whereas, Common retail prescription medications are frequently and chronically ‘backordered’
15 at a retail pharmacy, but often readily available at the hospital; therefore be it
16
17 RESOLVED, That our American Medical Association conduct a study which will investigate the
18 role pharmacy benefit managers play in drug shortages. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 504
(A-22)

Introduced by: New York

Subject: Scientific Studies Which Support Legislative Agendas

Referred to: Reference Committee E

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

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

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

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

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

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

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

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

RESOLVED, That our American Medical Association continue and expand its efforts to work with allied groups, health care policy influencers such as think tanks, and entities that can produce high quality scientific evidence, to help generate support for the AMA's key advocacy goals. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 03/22/22

RELEVANT AMA POLICY

Statement of Collaborative Intent G-620.030
(1) The AMA House of Delegates endorses the following preamble of a Statement of Collaborative Intent: The Federation of Medicine is a collaborative partnership in medicine. This partnership is comprised of the independent and autonomous medical associations in the AMA House of Delegates and their component and related societies. As the assemblage of the Federation of Medicine, the AMA House of Delegates is the framework for this partnership. The goals of the Federation of Medicine are to: (a) achieve a unified voice for organized medicine;
(b) work for the common good of all patients and physicians;
(c) promote trust and cooperation among members of the Federation; and
(d) advance the image of the medical profession; and (e) increase overall efficiency of organized medicine for the benefit of our member physicians.
(2) The AMA House of Delegates endorses the following principles of a Statement of Collaborative Intent: (a) Organizations in the Federation will collaborate in the development of joint programs and services that benefit patients and member physicians.
(b) Organizations in the Federation will be supportive of membership at all levels of the Federation.
(c) Organizations in the Federation will seek ways to enhance communications among physicians, between physicians and medical associations, and among organizations in the Federation.
(d) Each organization in the Federation of Medicine will actively participate in the policy development process of the House of Delegates.
(e) Organizations in the Federation have a right to express their policy positions.
(f) Organizations in the Federation will support, whenever possible, the policies, advocacy positions, and strategies established by the Federation of Medicine.
(g) Organizations in the Federation will support an environment of mutual trust and respect.
(h) Organizations in the Federation will inform other organizations in the Federation in a timely manner whenever their major policies, positions, strategies, or public statements may be in conflict.
(i) Organizations in the Federation will support the development and use of a mechanism to resolve disputes among member organizations.
(j) Organizations in the Federation will actively work toward identification of ways in which participation in the Federation could benefit them.
(CLRPD/CEJA/C&B Report, A-97; Consolidated: CLRPD Rep. 3, I-01; Modified: BOT Rep. 23, A-02; Modified: CCB/CLRPD Rep. 3, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 505
(A-22)

Introduced by: Illinois

Subject: CBD Oil Use and the Marketing of CBD Oil

Referred to: Reference Committee E

Whereas, Cannabidiol (CBD) oil is advertised in health clubs and convenience stores and online; and

Whereas, CBD oil is often marketed in ways that falsely imply medical doctor approval, verification or endorsement; and

Whereas, There is only one Food and Drug Administration (FDA)-approved drug in which CBD is the active ingredient for the indication of two rare types of epilepsy syndromes; and

Whereas, It is known that the side effects of CBD include elevated liver enzymes, diarrhea, somnolence and decreased appetite; and

Whereas, CBD oil is promoted for the treatment of a vast range of mental and physical ailments including: seizures, schizophrenia, depression, anxiety, Tourette syndrome, ADHD, pain reduction and sleep disorders; and

Whereas, CBD is one of more than 100 identified compounds in the cannabis plant, commonly known as marijuana and CBD is put into products including ingestible oils, bath salts and drinks; and

Whereas, CBD oil is not an FDA-approved product and is considered a dietary supplement and the composition and purity of the product generally extracted from hemp is not overseen by any U.S. regulatory body and adulteration, contamination with pesticides, herbicides and heavy metals and variable percentage of CBD product can and does occur; therefore be it

RESOLVED, That our American Medical Association support banning the advertising of cannabidiol (CBD) as a component of marijuana in places that children frequent (New HOD Policy); and be it further

RESOLVED, That our AMA support legislation to prohibit companies from selling CBD products if they make any unproven health and therapeutic claims, and to require companies to include a Food and Drug Administration-approved warning on CBD product labels. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/07/22

RELEVANT AMA POLICY

Regulation of Cannabidiol Products H-120.926
Our AMA will: (1) encourage state controlled substance authorities, boards of pharmacy, and legislative bodies to take the necessary steps including regulation and legislation to reschedule U.S. Food and Drug Administration (FDA)-approved cannabidiol products, or make any other necessary regulatory or legislative change, as expeditiously as possible so that they will be available to patients immediately after approval by the FDA and rescheduling by the U.S. Drug Enforcement Administration; (2) advocate that an FDA-approved cannabidiol medication should be governed only by the federal and state regulatory provisions that apply to other prescription-only products, such as dispensing through pharmacies, rather than by these various state laws applicable to unapproved cannabis products; and (3) support comprehensive FDA regulation of cannabidiol products and practices necessary to ensure product quality, including identity, purity, and potency.
Citation: Res. 502, A-18; Appended: CSAPH Rep. 3, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 506
(A-22)

Introduced by: Illinois

Subject: Drug Manufacturing Safety

Referred to: Reference Committee E

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1 Whereas, It has recently been revealed in the media as well as written notifications from
2 pharmacies informing the American public that certain medications produced outside but
3 consumed inside the United States have contained carcinogenic substances; and
4
5 Whereas, Such tainted medications are widely consumed within the US and include, but are not
6 limited to, Valsartan and Losartan; and
7
8 Whereas, Multiple medications are produced overseas and marketed broadly within the US; and
9
10 Whereas, Significant budgetary hurdles exist in empowering the U.S. Food and Drug
11 Administration to inspect all foreign drug manufacturers on a frequent and rigorous basis;
12 therefore be it
13
14 RESOLVED, That our American Medical Association support efforts to ensure that the U.S.
15 Food and Drug Administration (FDA) resumes safety testing for all drug manufacturing facilities
16 on a frequent and rigorous basis, as done in the past (Directive to Take Action); and be it further
17
18 RESOLVED, That our AMA call for the FDA to reaffirm the safety of the manufacture of drugs
19 and the adequacy of volume in the pipeline. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/07/22

RELEVANT AMA POLICY

D-100.983 - Prescription Drug Importation and Patient Safety
Our AMA will: (1) support the legalized importation of prescription drug products by wholesalers and pharmacies only if: (a) all drug products are Food and Drug Administration (FDA)-approved and meet all other FDA regulatory requirements, pursuant to United States laws and regulations; (b) the drug distribution chain is "closed," and all drug products are subject to reliable, "electronic" track and trace technology; and (c) the Congress grants necessary additional authority and resources to the FDA to ensure the authenticity and integrity of prescription drugs that are imported; (2) oppose personal importation of prescription drugs via the Internet until patient safety can be assured; (3) review the recommendations of the forthcoming report of the Department of Health and Human Services (HHS) Task Force on Drug Importation and, as appropriate, revise its position on whether or how patient safety can be assured under legalized drug importation; (4) educate its members regarding the risks and benefits associated with drug importation and reimportation efforts;
(5) support the in-person purchase and importation of Health Canada-approved prescription

drugs obtained directly from a licensed Canadian pharmacy when product integrity can be assured, provided such drugs are for personal use and of a limited quantity; (6) advocate for an increase in funding for the US Food and Drug Administration to administer and enforce a program that allows the in-person purchase and importation of prescription drugs from Canada, if the integrity of prescription drug products imported for personal use can be assured; and (7) support the personal importation of prescription drugs only if: (a) patient safety can be assured; (b) product quality, authenticity and integrity can be assured; (c) prescription drug products are subject to reliable, “electronic” track and trace technology; and (d) prescription drug products are obtained directly from a licensed foreign pharmacy, located in a country that has statutory and/or regulatory standards for the approval and sale of prescription drugs that are comparable to the standards in the United States. BOT Rep. 3, I-04 Reaffirmation A-09 Reaffirmed in lieu of: Res. 817, I-16 Appended: CMS Rep. 01, I-18 Appended: Res. 115, A-19

FDA Drug Safety Policies D-100.978
Our AMA will monitor and respond, as appropriate, to the implementation of the drug safety provisions of the Food and Drug Administration Amendments Act of 2007 (FDAAA; P.L. 110-85) so that the Food and Drug Administration can more effectively ensure the safety of drug products for our patients.
Citation: Sub. Res. 505, A-08; Reaffirmed: CSAPH Rep. 1, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 507
(A-22)

Introduced by: Illinois

Subject: Federal Initiative to Treat Cannabis Dependence

Referred to: Reference Committee E

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1 Whereas, There is no effective medication for treating dependence on cannabis; and
2
3 Whereas, Many states are making cannabis available for recreational purposes; and
4
5 Whereas, It is well known the use of cannabis can lead to addiction; and
6
7 Whereas, Physicians have no Food and Drug Administration-approved, safe and effective
8 medication to assist in treating cannabis addiction; therefore be it
9

10 RESOLVED, That our American Medical Association urge the National Institutes of Health to
11 award appropriate incentive grants to universities, pharmaceutical companies and other capable
12 entities to develop treatment options for cannabis dependence; and that the cost of these grants
13 be financed by taxes on those who profit from selling cannabis. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/07/22

Reference:

Lintzeris, N and associates, Nabiximois for the treatment of cannabis dependence: A randomized clinical trial, JAMA Intern Med, 2019; 179(9):1242-1253

RELEVANT AMA POLICY

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924
Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency

department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.
Citation: CSAPH Rep. 05, I-17; Appended: Res. 913, I-19; Modified: CSAPH Rep. 4, I-20

D-95.969 - Cannabis Legalization for Medicinal Use
Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; (6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians; and (7) encourages hospitals and health systems to: (a) not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use; and (b) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome. CSAPH Rep. 05, I-17 Appended: Res. 211, A-18 Appended: CSAPH Rep. 3, I-19

H-95.952 - Cannabis and Cannabinoid Research
1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.
2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.

3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.
4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.
5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.
6. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.
7. Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public. CSA Rep. 10, I-97 Modified: CSA Rep. 6, A-01 Modified: CSAPH Rep. 3, I-09 Modified in lieu of Res. 902, I-10 Reaffirmed in lieu of Res. 523, A-11 Reaffirmed in lieu of Res. 202, I-12 Reaffirmed: CSAPH Rep. 2, I-13 Modified: CSAPH Rep. 05, I-17 Reaffirmed in lieu of: Res. 434, A-19 Appended: Res. 913, I-19

H-95.923 - Taxes on Cannabis Products
Our AMA encourages states and territories to allocate a substantial portion of their cannabis tax revenue for public health purposes, including: substance abuse prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts. CSAPH Rep. 05, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 508
(A-22)

Introduced by: Illinois

Subject: Supplemental Resources for Inflight Medical Kit

Referred to: Reference Committee E

Whereas, According to the Bureau of Transportation Statistics, 770 million passengers boarded domestic flights in the United States in the year 2018 and 802 million passengers boarded domestic flights in the US in the year 2019; and

Whereas, Inflight medical emergencies (IMEs) are estimated to occur in approximately 1 in 604 flights, or 24 to 130 IMEs per 1 million passengers; and

Whereas, IMEs are common and occur in constrained areas with limited medical resources; and

Whereas, Inflight medical events are increasingly frequent because a growing number of individuals with pre-existing medical conditions travel by air; and

Whereas, The most common inflight emergency involves syncope or near syncope, which requires measurement of blood pressure and pulse for optimal assessment; and

Whereas, Travelers with diabetes may have altered dietary habits and medication dosing, so are at risk for hyper- or hypoglycemia; and

Whereas, Health care personnel are asked to assist affected passengers and have variable level of training and expertise in evaluating vital signs; and

Whereas, Efforts by health care volunteers are protected by Good Samaritan laws, there is an obligation and opportunity to optimize treatment in these situations; and

Whereas, The minimum requirements for the emergency medical kit do not include automated blood pressure cuff, pulse oximeter or glucose monitors; and

Whereas, The noise level of the airplane makes it difficult to auscultate for blood pressure, with cruising noise levels at around 85 dB but up to 105 dB during takeoff and landing; and

Whereas, Resources include automated external defibrillators, advanced life support injectables including epinephrine, atropine, lidocaine, analgesics, and first aid materials, but do not include pulse oximeters, automated blood pressure cuffs or glucose monitors; and

Whereas, Treatment and support decisions can be optimized with accurate vital signs, oxygen levels and blood sugar levels; and

Whereas, Blood glucose testing equipment is not required in the U.S.; and

Whereas, A pulse oximeter is a lightweight and inexpensive device that can determine heart rate as well as oxygen saturation; and

Whereas, An automated blood pressure cuff is a lightweight, inexpensive device that uses a pressure sensor and not sound to detect intraarterial systolic blood pressure; and

Whereas, A glucose monitor is a lightweight and relatively inexpensive device that can provide an accurate point of care blood sugar level; and

Whereas, A pulse oximeter, an automated blood pressure cuff and a glucose monitor are not among the standard supplies on a domestic U.S. flight; and

Whereas, The costs of these devices is minimal in comparison to the cost of diverting a flight for emergency medical attention due to inadequate evaluation on board; and

Whereas, In the absence of medical personnel during an inflight emergency, a pulse oximeter, automated blood pressure cuff and glucose monitor can be used to determine accurate data that can be shared with on ground medical support team; therefore be it

RESOLVED, That our American Medical Association advocate for U.S. passenger airlines to carry standard pulse oximeters, automated blood pressure cuffs and blood glucose monitoring devices in their emergency medical kits. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/07/22

References:

American Speech-Language-Hearing Association (ASHA). Feb 25, 2014 Durden, Rick Pulse Oximeters: Too Cheap to Ignore. The Aviation Consumer, October 29, 2019
https://www.bts.gov/

Martin-Gill, C, Doyle, TJ Yealy, DM, In Flight Emergencies: A Review. JAMA 2018 Dec 25;320(24):2580-2590. doi: 10.1001/jama.2018.19842.

RELEVANT AMA POLICY

H-45.981- Improvement in US Airlines Aircraft Emergency Kits

1. Our AMA urges federal action to require all US air carriers to report data on in-flight medical emergencies, specific uses of in-flight medical kits and emergency lifesaving devices, and unscheduled diversions due to in-flight medical emergencies; this action should further require the Federal Aviation Administration to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of in-flight medical emergencies and issue recommendations regarding the contents of in-flight medical kits and the use of emergency lifesaving devices aboard commercial aircraft.
2. Our AMA will: (a) support the addition of naloxone to the airline medical kit; (b) encourage airlines to voluntarily include naloxone in their airline medical kits; and (c) encourage the addition of naloxone to the emergency medical kits of all US airlines (14CFR Appendix A to Part 121 - First Aid Kits and Emergency Medical Kits). Res. 507, A-97 Amended: CSA Rep. 3, I-99 Reaffirmed: CSAPH Rep. 1, A-09 Reaffirmed in lieu of: Res. 502, A-16 Appended: Res. 524, A-18

H-45.979 - Air Travel Safety
Our AMA: (1) encourages the ongoing efforts of the Federal Aviation Administration, the airline industry, the Aerospace Medical Association, the American College of Emergency Physicians, and other appropriate organizations to study and implement regulations and practices to meet the health needs of airline passengers and crews, with particular focus on the medical care and treatment of passengers during in-flight emergencies; (2) encourages physicians to inform themselves and their patients on the potential medical risks of air travel and how these risks can be prevented; and become knowledgeable of medical resources, supplies, and options that are available if asked to render assistance during an in-flight medical emergency; and (3) will support efforts to educate the flying physician public about in-flight medical emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs, and such educational course will be made available online as a webinar. CSA Rep. 5, I-98 Appended: CSA Rep. 3, I-99 Reaffirmed: CSAPH Rep. 1, A-09 Appended: Res. 718, A-14 Reaffirmation I-14 Reaffirmed in lieu of Res. 503, A-15 Reaffirmed in lieu of: Res. 502, A-16 Reaffirmed in lieu of: Res. 516, A-17 Reaffirmed: BOT Rep. 22, A-18 Reaffirmed: BOT Rep. 30, A-18

H-45.978 - In-flight Medical Emergencies
Our AMA urges: (1) urges that decisions to expand the contents of in-flight emergency medical kits and place emergency lifesaving devices onboard commercial passenger aircraft be based on empirical data and medical consensus; in-flight medical supplies and equipment should be tailored to the size and mission of the aircraft, with careful consideration of flight crew training requirements; and (2) the Federal Aviation Administration to work with appropriate medical specialty societies and the airline industry to develop and implement comprehensive in-flight emergency medical systems that ensure:
(a) rapid 24-hour access to qualified emergency medical personnel on the ground;
(b) at a minimum, voice communication with qualified ground-based emergency personnel;
(c) written protocols, guidelines, algorithms, and procedures for responding to in-flight medical emergencies;
(d) efficient mechanisms for data collection, reporting, and surveillance, including development of a standardized incident report form;
(e) adequate medical supplies and equipment aboard aircraft;
(f) routine flight crew safety training;
(g) periodic assessment of system quality and effectiveness; and
(h) direct supervision by physicians with appropriate training in emergency and aerospace medicine. CSA Rep. 3, I-99 Reaffirmed: CSAPH Rep. 1, A-09 Reaffirmation I-14 Reaffirmed in lieu of: Res. 502, A-16 Reaffirmed in lieu of: Res. 516, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 509
(A-22)

Introduced by: Illinois

Subject: Regulation and Control of Self-Service Labs

Referred to: Reference Committee E

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1 Whereas, In recent years the number of laboratories selling self-ordered tests to patients has
2 increased significantly; and
3
4 Whereas, Laboratories advertise and promote their business on the Internet, and include
5 companies like HealthOneLabs, Accesa Labs, Private MD Labs, Walk-In--Lab, HNL Lab Tests
6 Direct, and several others; and
7
8 Whereas, Most laboratories selling self-ordered tests to patients state that their tests are run
9 with high-quality controls and procedures, and that correct and validated results are emailed to
10 the consumer directly; and
11
12 Whereas, Laboratories that sell self-ordered tests directly to patients clearly state that no
13 medical referral is needed, and that their results are validated and reviewed by an “independent
14 network of physicians,” of unspecified qualifications or licensures; and
15
16 Whereas, Many patients self-order tests out of fear or ignorance, and end up with results that
17 they are unable to interpret or apply to their individual needs; and
18
19 Whereas, Many patients go to their physician with pages of results which they may not have
20 needed in the first place and try to obtain a diagnostic interpretation and/or a therapeutic
21 intervention based on said results, which places the physician at medical and legal jeopardy;
22 therefore be it
23
24 RESOLVED, That our American Medical Association study issues with patient-directed self-
25 service testing, including the accreditation and licensing of laboratories that sell self-ordered
26 tests and physician liability related to non-physician-ordered tests. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/07/22

RELEVANT AMA POLICY

Direct-to-Consumer Laboratory Testing H-480.941
Our AMA will: (1) advocate for vigilant oversight of direct-to-consumer (DTC) laboratory testing by relevant state and federal agencies; and (2) encourage physicians to educate their patients about the risks and benefits of DTC laboratory tests, as well as the risks associated with interpreting DTC test results without input from a physician or other qualified health care professional.
Citation: Res. 526, A-18; Reaffirmed: BOT Rep. 12, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 510
(A-22)

Introduced by: Colorado, American Academy of Ophthalmology, GLMA: Health Professionals Advancing LGBTQ Equality, Society of Critical Care Medicine, American Society of Transplant Surgeons, American Society of Cataract and Refractive Surgery, California

Subject: Evidence-Based Deferral Periods for MSM Corneas and Tissue Donors

Referred to: Reference Committee E

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1 Whereas, On May 20, 1994, the US Public Health Service instituted a policy prohibiting
2 donation of corneas and other tissues by "[men] who have had sex with another man [MSM] in
3 the preceding 5 years" even if all required infectious disease testing is negative,[1] a policy which
4 continues to be enforced today by the US Food and Drug Administration (FDA)[2]; and
5
6 Whereas, The 5-year MSM deferral policy was instituted at a time when HIV tests were
7 unreliable and has not been updated to reflect advances in HIV testing since 1994[3,4]; and
8
9 Whereas, All corneal donors are required to undergo HIV testing, which is now reliable within
10 4-8 days of viral exposure[5,6]; and
11
12 Whereas, No case of HIV transmission from a corneal transplant has ever been reported, even
13 in cases when the corneal donors were HIV-positive[3,7,8,9,10,11]; and
14
15 Whereas, Corneas are an avascular tissue and are not a major reservoir of HIV[12]; and
16
17 Whereas, Current FDA policy treats MSM corneal donors more strictly than other potentially
18 high-risk donors (e.g. while MSM donors must be abstinent for 5 years, heterosexual donors in
19 a sexual relationship with someone known to be HIV-positive are only ineligible for 1 year after
20 last sexual contact with an HIV-positive individual)[2]; and
21
22 Whereas, MSM blood donors are only ineligible for 3 months after last sexual contact, despite
23 the known risk of HIV transmission through blood transfusions[13]; and there is no deferral period
24 whatsoever for MSM donors of solid organs (such as hearts, lungs, kidneys, etc.)[14,15]; and
25
26 Whereas, Many peer nations have no deferral period for MSM corneal donors whatsoever (e.g.
27 Spain,[16] Italy,[17] Mexico,[18] Chile,[19] Argentina,[20] Germany,[21] Denmark,[22] South Africa[23]); and
28
29 Whereas, Many other peer nations have deferral periods for MSM corneal donors far shorter
30 than 5 years (e.g. 3 months in the United Kingdom,[24] 4 months in the Netherlands,[25] 4 months in
31 France,[26] 12 months in Canada[27]); and
32
33 Whereas, AMA Policy H-50.973, "Blood Donor Deferral Criteria," states that AMA supports
34 blood donor deferral criteria that are "representative of current HIV testing technology" but does
35 not address the FDA's even stricter deferral criteria for MSM donors of corneas and other
36 tissues[28]; and

Whereas, A recent *JAMA Ophthalmology* study estimated that between 1558 and 3217 potential corneal donations were disqualified in 2018 alone in the United States and Canada due to the two countries' bans on MSM corneal donors[3]; and

Whereas, An estimated 12.7 million visually impaired patients are in need of corneal transplant surgery worldwide, with only 1 cornea donated for every 70 corneal transplants needed[29]; therefore be it

RESOLVED, That our American Medical Association amend current policy H-50.973, "Blood Donor Deferral Criteria," by addition and deletion as follows:

> Blood and Tissue Donor Deferral Criteria
> Our AMA: (1) supports the use of rational, scientifically-based ~~blood and tissue donation~~ deferral periods for donation of blood, corneas, and other tissues that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence; (3) supports a blood and tissue donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology; and (4) supports research into individual risk assessment criteria for blood and tissue donation (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA continue to lobby the United States Food and Drug Administration to use modern medical knowledge to revise its decades-old deferral criteria for MSM donors of corneas and other tissues. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

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RELEVANT AMA POLICY

Blood Donor Deferral Criteria H-50.973

Our AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence; (3) supports a blood donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology; and (4) supports research into individual risk assessment criteria for blood donation.
Citation: Res. 514, A-13; Modified: Res. 008, I-16; Modified: Res. 522, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 511
(A-22)

Introduced by: Illinois

Subject: Over the Counter (OTC) Hormonal Birth Control

Referred to: Reference Committee E

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1 Whereas, Many individuals prefer to have control over the timing and occurrence of pregnancy;
2 and
3
4 Whereas, Oral hormonal contraception birth control pills is available and very effective; and
5
6 Whereas, Safety considerations of birth control pills have been well reviewed and largely
7 reduced for incidences of untoward complications; and
8
9 Whereas, The availability of birth control pills may reduce incidence of unexpected and
10 unwanted pregnancy that may result in abortion and its risks; and
11
12 Whereas, Birth control pills are currently only available by prescription of a physician; and
13
14 Whereas, The American College of Obstetricians and Gynecologists recommends the
15 elimination of the physician prescription requirement and allowing oral contraceptives (birth
16 control pills) to be sold without a prescription; therefore be it
17
18 RESOLVED, That our American Medical Association recommend elimination of the requirement
19 for a physician's prescription to purchase birth control pills (BCP) and over the counter (OTC)
20 hormonal contraceptives and allow OTC purchase (New HOD Policy); and be it further
21
22 RESOLVED, That our AMA advocate for the revocation of Food and Drug Administration and/or
23 Congressional regulations requiring a prescription for OTC hormonal BCP. (Directive to Take
24 Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

RELEVANT AMA POLICY

Over-the-Counter Access to Oral Contraceptives D-75.995
Our AMA:
1. Encourages manufacturers of oral contraceptives to submit the required application and supporting evidence to the US Food and Drug Administration for the Agency to consider approving a switch in status from prescription to over-the-counter for such products.
2. Encourages the continued study of issues relevant to over-the-counter access for oral contraceptives.
Citation: Sub. Res. 507, A-13; Modified: BOT Rep. 10, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 512
(A-22)

Introduced by: Mississippi

Subject: Scheduling and Banning the Sale of Tianeptine in the United States

Referred to: Reference Committee E

Whereas, While Tianeptine is approved in some countries to treat depression and anxiety, it is an unapproved drug in the United States due to safety concerns; and

Whereas, Tianeptine is legally sold over the counter in the United States commonly in gas stations and convenience stores; and

Whereas, The U.S. Food and Drug Administration (FDA) is warning consumers they may inadvertently find themselves addicted to tianeptine and should avoid all products containing it, especially those that claim to treat opioid use disorder since reliance on these products may delay appropriate treatment and put consumers at greater risk of overdose and death; and

Whereas, The FDA is aware of several serious adverse event reports including agitation, drowsiness, confusion, sweating, rapid heartbeat, high blood pressure, confusion, nausea, vomiting, slowed or stopped breathing, coma, and death associated with tianeptine and these reports are increasing with poison control centers cases nationwide from 11 cases between 2000 and 2013 to 151 in 2020 alone; and

Whereas, Tianeptine is not approved in the United States for any medical use; and

Whereas, Tianeptine is currently widely available for sale to the public, presenting safety risks and risk of abuse; and

Whereas, Tianeptine is not currently controlled under the Controlled Substances Act, but is being scheduled on a state-by-state basis as a Schedule II controlled substance, as recently passed in Alabama and Michigan. Schedule II drugs by definition mean that a substance may lead to severe psychological or physical dependence and joins other substances such as morphine, methamphetamine, cocaine, methadone, hydrocodone, fentanyl, and phencyclidine (PCP) in that class; therefore be it

RESOLVED, That our American Medical Association advocate to schedule Tianeptine as Schedule II whilst supporting research into the safety and efficacy of the substance (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate to ban the sale of Tianeptine directly to the public. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/07/22

https://www.fda.gov/consumers/consumer-updates/tianeptine-products-linked-serious-harm-overdoses-death
https://en.wikipedia.org/wiki/Tianeptine

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 513
(A-22)

Introduced by: Oklahoma

Subject: Education for Patients on Opiate Replacement Therapy

Referred to: Reference Committee E

Whereas, We are in a time of potentially increased respiratory illness, given the threat of COVID-19 and flu season in the United States; and

Whereas, We are simultaneously in a time of increased use of opiate replacement therapy for the treatment of opiate use disorder and chronic pain; and

Whereas, Anecdotally, a death scenario occurs when patients in their 60s and 70s who are on relatively high dose maintenance opioid replacement therapy, take their usual dose after onset of a respiratory illness, and

Whereas, AMA Policy D-95.987, “Prevention of Drug-Related Overdose,” is to educate physicians and at-risk patients, but it fails to specifically address the needs of older patients who are at risk of death from opiate maintenance therapy when the onset of respiratory illness occurs; therefore be it

RESOLVED, That our American Medical Association amend Policy D-95.987, “Prevention of Drug-Related Overdose,” by addition to read as follows:

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.

1 5. Our AMA implement an education program for patients on opiate replacement
2 therapy and their family/caregivers to increase understanding of their increased
3 risk of death with concurrent opiate maintenance therapy and the onset of a
4 serious respiratory illness such as SARS-CoV-2. (Modify Current HOD Policy)

References:
https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2020.20030348

Fiscal Note: Not yet determined

Received: 04/26/22

RELEVANT AMA POLICY

Prevention of Drug-Related Overdose D-95.987
1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
Citation: Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 514
(A-22)

Introduced by: Oklahoma

Subject: Oppose Petition to the DEA and FDA on Gabapentin

Referred to: Reference Committee E

Whereas, The mission of the American Medical Association is to promote the art and science of medicine and the betterment of public health; and

Whereas, Gabapentin is approved by the U.S. Food and Drug Administration (FDA) to treat specific forms of epilepsy and neuropathic pain;(1),(2) and Gabapentin enacarbil, which is approved by the FDA for treatment of primary restless legs syndrome and postherpetic neuralgia, is a prodrug of gabapentin, and, accordingly, its therapeutic effects are attributable to gabapentin(3); and

Whereas, From 2011 to 2017, total prescriptions for gabapentin doubled to 64.8 million prescriptions per year(4); and

Whereas, A watchdog nonprofit group Public Citizen has filed a petition on 2/08/2022 with the FDA and the U.S. Drug Enforcement Administration (DEA), arguing that gabapentin's risks warrant additional safeguards by requesting regulators to make the drug a controlled substance(5); and

Whereas, Public Citizen noted as of November 2020, seven states--Alabama, Kentucky, Michigan, North Dakota, Tennessee, Virginia, and West Virginia--had classified gabapentin as a schedule V drug, while another 12 states required prescription monitoring of the drug(5); and

Whereas, Public Citizen requested that gabapentin come under the DEA's Schedule V category, which already includes the similar drug, pregabalin (Lyrica); and

Whereas, Schedule V is the lowest rung on the DEA's drug schedule, meaning it has lower potential for abuse than Schedule I through IV drugs; and

Whereas, Patients with pain should receive treatment that provides the greatest benefit and opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care(6); and

Whereas, Evidence suggests that nonopioid treatments, including nonopioid medications and nonpharmacological therapies can provide relief to those suffering from chronic pain, and are safer(6); and

Whereas, Gabapentin has been a lower risk alternative for pain management than opioids in the fight against opioid overdose(6); and

Whereas, In 2019 the FDA issued a warning about serious breathing difficulties associated with gabapentin and pregabalin in patients with respiratory risk factors(7); and

Whereas, A systematic review on PubMed/Scopus that included 106 studies, did not find convincing evidence of a vigorous addictive power of gabapentinoids which is primarily suggested from their limited rewarding properties, marginal notes on relapses, and the very few cases with gabapentinoid-related behavioral dependence symptoms (ICD-10) in patients without a prior abuse history(8); and

Whereas, There was no publication about people who sought treatment for the use of gabapentinoids(8); and

Whereas, Pure overdoses of gabapentinoids appeared to be relatively safe but can become lethal (pregabalin > gabapentin) in mixture with other psychoactive drugs, especially opioids again and sedatives(8); and

Whereas, Making gabapentinoids, medications with little addictive or habit-forming potential, schedule V will make it more complicated for patients to receive treatment and causes an unnecessary barrier for care; therefore be it

RESOLVED, That our American Medical Association actively oppose the placement of (a) gabapentin (2-[1-(aminomethyl) cyclohexyl] acetic acid), including its salts, and all products containing gabapentin (including the brand name products Gralise and Neurontin) and (b) gabapentin enacarbil (1-{[({(1RS)-1-[(2- methylpropanoyl)oxy]ethoxy} carbonyl)amino]methyl} cyclohexyl) acetic acid), including its salts, (including the brand name product Horizant) into schedule V of the Controlled Substances Act (Directive to Take Action); and be it further

RESOLVED, That our AMA submit a timely letter to the Commissioner of the U.S. Food and Drug Administration for the proceedings assigned docket number FDA-2022-P-0149 in opposition to placement of gabapentin and gabapentin enacarbil into the schedule V of the Controlled Substance Act. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/26/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 515
(A-22)

Introduced by: Senior Physicians Section

Subject: Reducing Polypharmacy as a Significant Contributor to Senior Morbidity

Referred to: Reference Committee E

Whereas, Excessive, unnecessary, or incompatible medication use increases the risk of adverse drug effects, including falls, cognitive impairment, adverse drug interactions and drug-disease interactions;[1, 4, 5] and

Whereas, Older patients often have multiple complex conditions making drug therapy an essential part of medical management; yet multiple medications in complex patients may shift the benefit of drug therapy from positive to negative;[2, 6] and

Whereas, Although some EHRs are automatically screening patient med lists for incompatibilities, they may not include supplements and OTC meds; and fidelity with actual current regimens is compromised when self reporting is relied upon, especially in the setting of cognitive decline; and

Whereas, Consumer patient education on polypharmacy has been raised by such groups as AARP, Consumer Reports, and governmental units such as CDC with questionable penetrance to the affected population; and

Whereas, Physicians are the natural source for patient education and engagement;[3] and

Whereas, It is advisable for the AMA to use its resources to educate patients about the dangers of polypharmacy, and to assist physicians to take steps to recognize and reduce it;[7-10] therefore be it

RESOLVED, That our American Medical Association work with other organizations e.g., AARP, other medical specialty societies, PhRMA, and pharmacists to educate patients about the significant effects of all medications and most supplements, and to encourage physicians to teach patients to bring all medications and supplements or accurate, updated lists including current dosage to each encounter (Directive to Take Action); and be it further

RESOLVED, That our AMA along with other appropriate organizations encourage physicians and ancillary staff if available to initiate discussions with patients on improving their medical care through the use of only the minimal number of medications (including prescribed or over-the-counter, including vitamins and supplements) needed to optimize their health (Directive to Take Action); and be it further

RESOLVED, That our AMA work with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records, and to include non-prescription medicines in medication compatibility screens. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/03/22

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RELEVANT AMA POLICY

Improving the Quality of Geriatric Pharmacotherapy H-100.968

Our AMA believes that the Food and Drug Administration should encourage manufacturers to develop low dose formulations of medications commonly used by older patients in order to meet the special needs of this group; require geriatric-relevant labeling for over-the-counter medications; provide incentives to pharmaceutical manufacturers to better study medication effects in the frail elderly and oldest-old in pre- and post-marketing clinical trials; and establish mechanisms for data collection, monitoring, and analysis of medication-related problems by age group.
Citation: CSA Rep. 5, A-02; Reaffirmation A-10; Reaffirmed: CSAPH Rep. 01, A-20

Supporting Safe Medical Products as a Priority Public Health Initiative H-120.958

Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names; (2) continue participation on the National Coordinating Council for Medication Error Reporting and Prevention; (3) support the FDA's Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events; (4) vigorously work to support and encourage efforts to create and expeditiously implement a national coding system for prescription medicine packaging in an effort to improve patient safety; and (5) seek opportunities to work collaboratively with other stakeholders to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety.
Citation: Res. 416, A-99; Appended: Res. 504, I-01; Reaffirmation A-10; Modified: CSAPH Rep. 01, A-20

Geriatric Medicine H-295.981

1. Our AMA reaffirms its support for: (a) the incorporation of geriatric medicine into the curricula of medical school departments and its encouragement for further education and research on the problems of aging and health care of the aged at the medical school, graduate and continuing medical education levels; and (b) increased training in geriatric pharmacotherapy at the medical student and residency level for all relevant specialties and encourages the Accreditation Council

for Graduate Medical Education and the appropriate Residency Review Committees to find ways to incorporate geriatric pharmacotherapy into their current programs.

2. Our AMA recognizes the critical need to ensure that all physicians who care for older adults, across all specialties, are competent in geriatric care, and encourages all appropriate specialty societies to identify and implement the most expedient and effective means to ensure adequate education in geriatrics at the medical school, graduate, and continuing medical education levels for all relevant specialties.
Citation: Res. 137, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Appended: CSA Rep. 5, A-02; Appended: Res. 301, A-10; Reaffirmed: BOT Rep. 05, I-16

National Health Information Technology D-478.995
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.
Citation: Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified:

BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 3, I-19

Reference Committee F

BOT Report(s)

01 Annual Report
04 AMA 2023 Dues
11 Procedure for Altering the Size or Composition of Section Governing Councils
16 Language Proficiency Data of Physicians in the AMA Masterfile
20 Delegate Apportionment and Pending Members

Joint Report(s)

CCB/CLRPD 01 Joint Council Sunset Review of 2012 House Policies

Resolution(s)

601 Development of Resources on End-of-Life Care
602 Report on the Preservation of Independent Medical Practice
603 September 11th as a National Holiday
604 UN International Radionuclide Therapy Day Recognition
605 Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis
606 Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System
607 AMA Urges Health and Life Insurers to Divest of Investments of Fossil Fuels
608 Transparency of Resolution Fiscal Notes
609 Surveillance Management System for Organized Medicine Policies and Reports
610 Making AMA Meetings Accessible

REPORT OF THE BOARD OF TRUSTEES

B of T Report 1-A-22

Subject: Annual Report

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee F

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.

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AMA
AMERICAN MEDICAL ASSOCIATION

SUPPORTING PHYSICIANS. STRENGTHENING THEIR VOICE.

ANNUAL **REPORT**

2021

FINANCIAL HIGHLIGHTS

(Dollars in millions)	2021	2020
Revenues	$ 459.7	$ 433.4
Cost of products sold and selling expense	25.9	29.3
General and administrative expenses	352.3	342.1
Operating results	77.9	56.0
Non-operating items	79.5	56.1
Changes in defined benefit postretirement plans, other than periodic expense, net of tax	5.6	(2.8)
Change in unrestricted equity	163.0	109.3
Change in donor restricted equity	(0.1)	(1.5)
Change in association equity	162.9	107.8
Association equity at year-end	$894.9	$732.0
Employees at year-end	1,206	1,215

Association operating results

(in millions)

* *Pro forma operating results: 1) 2013 excludes $33 million in nonrecurring charges relating to AMA's headquarters relocation and 2) 2019 excludes $36.2 million noncash pension termination expense reclassification from non-operating results.*

** *Both 2020 and 2021 results were impacted by a freeze in hiring and cancellation of all travel and meetings during the year due to the pandemic. These savings are temporary in nature.*

LETTER TO STAKEHOLDERS

As we entered year two of the COVID-19 pandemic, a health care crisis unlike anything we have experienced in decades, physicians and health care workers in 2021 continued going to extraordinary lengths to protect American lives. Whether battling the virus in hospitals or working to dispel misinformation and build trust in science and vaccines, physicians have been cornerstones of care, compassion and sheer determination.

Throughout these immense challenges physicians have been buoyed by the support of the American Medical Association, which delivered tools and resources and has been their advocate for change through the courts, in Congress and with a new administration.

By elevating the urgent concerns of physicians and patients, the AMA helped secure broad telehealth expansion, delivering potentially life-saving remote care to more people in more areas and a lifeline to independent practices struggling to weather the economic storm of COVID-19.

In addition, AMA advocacy netted critical funding through Congress to sustain physician practices and bolster the health care safety net in local communities.

As one of the nation's leading voices for science and vaccination, the AMA fought through the courts to uphold vaccine requirements for health care workers and others, and we joined forces with other top organizations and the Ad Council to promote a sweeping public education campaign to build confidence in the safety and efficacy of vaccines.

To keep physicians informed about the ever-changing landscape around COVID-19, to guide physician practices on safely reopening following lockdowns, and to give expert insights on managing mental health and coping with stress during the pandemic, the AMA created dozens of evidence-based resources and communicated in a consistent, professional manner in battling vaccine misinformation and falsehoods.

The AMA worked collaboratively to develop programs, resources and strategies to embed racial justice and advance health equity, improve outcomes for historically marginalized populations that suffered disproportionately during the pandemic, and educate physicians about longstanding health inequities and their impact on people and communities.

Despite the disruptions from the past year, the AMA continued its work in support of physicians and patients by strongly advocating on such issues as: critical prior authorization and step therapy reforms in Washington, D.C., and across many states; delivering tools to help those at risk better track their blood pressure results; and by pushing policymakers to remove barriers to evidence-based treatments for substance use disorders and for patients coping with pain.

As more physicians recognize the AMA as their powerful ally in patient care, the AMA reported its 11th consecutive year of membership growth. We also recorded another strong year of financial performance largely due to temporary pandemic-related savings resulting from less travel, fewer meetings and conferences, and unfilled staff positions. The AMA's history of solid financial performance will support our mission activities in the years to come.

For all that has changed in health care and in our world during this pandemic, the AMA remains more committed than ever to elevating the physician voice, advancing equity, and embracing our mission to promote the art and science of medicine and the betterment of public health.

Bobby Mukkamala, MD
Chair, Board of Trustees

Michael Suk, MD, JD, MPH, MBA
Finance Committee Chair, Board of Trustees

James L. Madara, MD
CEO and Executive Vice President

“I have a radical idea: When it comes to medicine [and] health care advice, I think doctors should be the loudest, most vocal in the room. Not politicians, not TV hosts, not celebrities and not the folks peddling conspiracy theories.”

Gerald Harmon, MD

Family medicine

President, American Medical Association

A practicing family medicine specialist in coastal South Carolina and retired major general who served the nation in the Air Force Reserve, Dr. Harmon believes “physicians have a responsibility to speak out on matters of public health. Far too many people are listening to the wrong experts on COVID-19 and vaccine science. The AMA is working to fix that.”

At the time of this writing, our nation has lost almost 965,000 lives to COVID-19 … and that number is growing. As shocking and heartbreaking as that figure is, we have made real progress since 2020. Our understanding of the virus and its variants has expanded significantly. We now have vaccines—as well as treatments and therapeutic options—to reduce the severity of the disease and death. No longer is a lack of understanding or evidence impeding our ability to get past this pandemic.

The voices we hear on television, radio and in town hall meetings are passionate and convincing. The misinformation permeating our daily lives can feel overwhelming. News programs from across the world, social media posts, protests, conversations around virtual water coolers—never has there been so much attention on matters of public health, on equity in medicine, and on science and technology. Americans today are bombarded with opinions rooted more deeply in ideologies and identities than in facts and concrete science.

For medicine and health care, the stakes have never been higher.

Despite these challenges, the AMA believes physicians have a unique opportunity—a responsibility—to be ambassadors for truth, science and sound health care policies in ways never seen before. Physicians are trusted by their patients. Years dedicated to patient care—treating diseases, delivering babies, healing injuries, developing relationships—is the foundation of trust that is essential in the patient-physician relationship. And it's this trust that allows us to cut through the noise to educate our patients and help them make informed decisions about their health.

When it comes to health care, vaccines, COVID treatments, gun violence, e-cigarettes and more, the AMA wants *physician* voices to be the loudest and most credible ones heard outside of the exam room … not politicians, not news personalities, not celebrities.

THIS IS OUR CHARGE. AND THIS IS YOUR CHANCE.

The AMA provides physicians with the tools and support to deliver what the public needs: accurate, evidence-based information. In a time of so much misinformation and anti-science rhetoric, the AMA will continue to support physicians and elevate their voices on issues that matter to patients and that advance public health. We celebrate all physicians who are leading by example, championing science and combating misinformation in their communities, including the physicians featured on the following pages of this report.

> ***... [A]t some point, to save lives, you have to be able to have a frank discussion.***

Peter Hotez, MD, PhD

Pediatrics

Dr. Hotez, one of the most visible and outspoken physicians on the side of science and evidence during the pandemic, said we need to call widespread and carefully orchestrated misinformation campaigns for what they are—"anti-science aggression" meant to undermine the advice of doctors and experts. For his far-reaching contributions to advance science and medicine, Dr. Hotez, who is dean of the National School of Tropical Medicine and professor of pediatrics and molecular virology and microbiology at Baylor College of Medicine, is a recipient of the AMA's Scientific Achievement Award, one of the organization's highest honors, and a nominee for the Nobel Peace Prize.

FOR PHYSICIANS

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 2021 to avert devastating Medicare physician payment cuts totaling nearly 10%**. AMA actions helped secure a Physician Fee Schedule increase and temporary sequester relief while blocking a significant Medicare PAYGO reduction in 2022.

The AMA worked together with more than 35 state medical associations across the country to defend the practice of medicine and defeat nonphysician providers' attempts to inappropriately expand their scope of practice. Our involvement was **critical in defeating bills that would have expanded scope of practice** for nurse practitioners, physician assistants and optometrists—to name a few.

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

AMA Insurance partnered with ArmadaCare, a leading insurance program manager, to offer a **new supplemental health insurance program for physician groups**. This move bolstered support for behavioral health and well-being in the face of pandemic-induced stress.

The AMA elevated the voice of leaders and experts who spoke on the importance of science and other critical issues of public health during the pandemic, **securing more than 94 billion media impressions** in the process. This impact underscores the AMA as the leader among U.S. health care organizations in media share of voice during COVID-19.

In another top-priority state advocacy issue, the AMA **worked in collaboration with state medical associations and national medical specialties to reduce the burden of prior authorization** on patients and physicians. Prior authorization legislation based on the AMA's model bill was introduced in several states and enacted in Illinois and Georgia.

Since its launch in May 2021, **two dozen state and specialty society partners have joined the AMA Telehealth Immersion Program**. This program—through its "Telehealth Quick Guide," "Telehealth Implementation," "Telehealth Educators" and "Remote Patient Monitoring Implementation" playbooks—has enabled thousands of physicians to improve their understanding of telehealth and streamline its implementation into their practices.

The AMA **worked with the CDC to provide innovative and highly effective infection control training for physicians** and other frontline health care workers through Project Firstline.

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

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 assessing 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 (BHI) 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 AMA November Special Meeting.

The popular **AMA STEPS Forward® online training program expanded** with eight new toolkits, 17 updated toolkits, more than two dozen webinars and 14 podcasts.

"Remember how much of a trusted voice you are in people's lives. You may not be at their dinner table. You may not be going home with them, but they are seriously taking what you tell them and they are sharing that with their loved ones and using that information to make decisions about their own lives and the lives of the people they care about."

Jerry Abraham, MD

Family medicine

Member, AMA Council on Constitution and Bylaws

A family physician from Los Angeles, Dr. Abraham stresses the importance of physicians remembering the profound trust patients place in them. "When you decide step up and speak out, your patients will trust you and they'll do the right thing."

"When the pandemic started and it looked like it was going to be politicized, I wanted to make sure that I got information out in nonpartisan ways so people could trust me as a physician and think, 'Okay, this goes beyond the politics that we're seeing. This is somebody that we know, we trust her credentials, we trust what she has to say.'"

Megan Srinivas, MD, MPH

Infectious disease

Member, AMA Council on Medical Service

Dr. Srinivas is focused on addressing disparities in health resource allocation. She is a respected voice on reaching patients from diverse backgrounds, saying that physicians need to approach that work in a simple and straightforward way.

"We have to tailor our approach to them. Explain to them how exactly the mRNA virus works, but do it in a culturally competent way that touches the population that you are trying to [reach]," Dr. Srinivas said.

FOR PATIENTS

AMA advocacy and legal efforts **played key roles in informing 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.

The AMA became **an important voice nationally about advancing equity and racial justice in medicine** with the launch of its multiyear strategic plan to embed equity across the organization and in all its actions.

The AMA was a tireless advocate for physicians in federal and state legal issues, and **our legal arguments and medical expertise proved instrumental in dismissing attempts to undermine the Affordable Care Act** and laws that would harm transgender youth.

The AMA partnered with the Ad Council and outside organizations in four national public service **campaigns designed to build confidence for COVID-19 vaccines, promote flu vaccination, and encourage more people—particularly from historically marginalized communities**—to better understand their risks for prediabetes and to take control of their heart health through self-monitoring blood pressure and conversations with their doctors.

The AMA successfully lobbied for use of the Defense Production Act to boost production of personal protective equipment, vaccines and onshore production of rapid COVID-19 tests. **AMA advocacy also successfully called for expanded testing and increased FDA Emergency Use Authorizations**.

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**.

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

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

A pandemic-inspired shift to virtual coaching **helped more health care organizations implement AMA MAP BP™**, our evidence-based quality improvement program that helps health care organizations improve blood pressure control.

The AMA's 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.

"COVID-19 has reminded all of us just how important our voice is, as advocates for science, evidence and most of all, for our patients' good health."

Bobby Mukkamala, MD

Otolaryngology

Chair, Board of Trustees, American Medical Association

Dr. Mukkamala is an otolaryngologist from Flint, Mich., who has been clear-eyed in recognizing the layers of complexity associated with the pandemic, noting how it has placed "an uncomfortable spotlight on many longstanding problems within our health care system, but it has also brought out the very best in our physician community."

"No venue is too small, whether it's going to your child's elementary school and talking about vaccines or picking up the phone and calling an editor of an article. Don't let any misinformation go by without responding to it."

Paul Offit, MD

Pediatrics

An attending physician within Children's Hospital of Philadelphia Division of Infectious Diseases, Dr. Offit lives by his own words. One of the most knowledgeable and vocal champions for childhood vaccinations throughout the pandemic, Dr. Offit has said influence can happen wherever a physician is willing to speak out. It's critical not to let misinformation go unchallenged.

FOR THE PROFESSION

The AMA Ed Hub™, an industry-leading online education platform, **had more than 6.4 million views and kept physicians informed on COVID-19, physician wellness, telemedicine, diabetes prevention, health equity** and a host of other topics. AMA Ed Hub content now includes education from 24 organizations in addition to the AMA.

With nearly 4 million visits to its website in 2021—and a popular podcast—the *AMA Journal of Ethics*® **provided expert ethical guidance to help physicians and medical students navigate complex decisions across a broad range of subjects**. And a new series of videos and podcasts addressed ethical dilemmas triggered or exacerbated by the pandemic.

The AMA created a cross-sector Equity and Innovation Advisory Group, **launched a series of equity-focused educational modules for CME credit on the AMA EdHub, 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.

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

The AMA's JAMA Network expanded its family of specialty journals with the launch of *JAMA Health Forum*, a peer-reviewed, open-access online journal focusing on health policy, health care systems, and global and public health. Meanwhile, **the JAMA Network® itself surpassed the 100-million mark of total sessions for the second straight year**, aided by its Coronavirus Resource Center, which has proven an essential and trusted source of information for physicians, researchers and patients.

The AMA's yearslong effort to reinvent medical school education across the continuum supported student and resident training in health systems science, telehealth and improvements in the transition from medical school to residency. ChangeMedEd21 drew record attendance, highlighted by the "Bright Ideas Showcase" in which **the AMA funded three grants to boost diversity and dismantle systemic racism in medical education**. A webinar on the impact of structural racism in medicine garnered more than 2,000 views.

"We are the ones on the frontline and know firsthand the impact misinformation can [have]. Promote accurate and positive information ... you never know whose life you may change."

Diana Ramos, MD, MPH

Obstetrics and gynecology

Dr. Ramos is a practicing physician in southern California and an adjunct associate professor of obstetrics and gynecology at the Keck USC School of Medicine in Los Angeles. Sharing personal stories and accurate information is what has helped her connect and make a real difference in the lives of her patients and community during the pandemic. "As physicians, we are the trusted voice. I feel responsible and grateful that I have the AMA as a partner for accurate information."

MANAGEMENT'S DISCUSSION AND ANALYSIS

Management's discussion and analysis

Introduction

The objective of this section is to help American Medical Association (AMA) members and other readers of our financial statements understand management's views on the AMA's financial condition and results of operations. This discussion should be read in conjunction with the audited consolidated financial statements and notes to the consolidated financial statements.

Improving the health of the nation is at the core of the AMA's work. In 2021, AMA continued to focus on the strategic arcs of addressing chronic disease, advancing professional development and removing obstacles in health care, through improving health outcomes, lifelong medical education and enhancing physician professional satisfaction and practice sustainability. Our advocacy, health equity and innovation initiatives act as accelerators across all arcs. AMA's foundation is built on science, membership, financial performance, talent and engagement, and marketing and communications.

2021 saw great progress on many important activities, including the expansion of AMA's Center for Health Equity, with development of a three year enterprise equity action plan and an internal health equity training curriculum helping to embed health equity in all the work of AMA; continuation of AMA's and the JAMA Network's COVID-19 resource centers as trusted sources for clear, evidence-based COVID-19 guidance; leading a coalition of more than 120 state and specialty societies that resulted in Congress acting to address a combined 9.75 percent in Medicare physician payment cuts set to take effect in 2022 and achieving critical government interventions on issues from the COVID-19 Public Health Emergency; ongoing development of projects in the Integrated Health Model Initiative to enable interoperable technology solutions and care models; spinoffs of four new companies in AMA's business formation and commercialization enterprise in Silicon Valley, Health2047, Inc. (Health2047); and expansion of the AMA Ed Hub, providing trusted, high-quality education to physicians and other members of the health care team who seek to stay current and continuously improve the care they provide.

The COVID-19 pandemic has had an extraordinary impact on AMA's financial results over the last two years, with temporary savings and revenue increases driving operating results to levels materially above any prior years. In 2021, AMA again financially benefitted from cost savings resulting from actions taken to limit the impact of COVID-19 on AMA.

During the first year of the pandemic in 2020, AMA had taken steps to minimize the risk of potential adverse economic effects that might affect AMA's funding and financial condition. These included a freeze on all open positions and limited expansion of activities in the 2021 budget. In early 2021, AMA lifted the freeze on hiring, but like other organizations, experienced challenges in filling positions due to the current tight job market. Savings from personnel costs and reduced travel and in-person meetings, coupled with savings from deferring certain programmatic activities and reduced office-related costs in the remote work environment, kept expenses well below the level budgeted for 2021.

Pro forma net operating results

(in millions)

Excluding the $36.2 million non-cash pension termination charge

Looking forward, AMA's 2022 budget assumes that these temporary savings will not recur, and coupled with expansion of certain programmatic areas, expenses will increase to normal levels, resulting in operating income at the board approved policy level.

The AMA is committed to its responsibility to ensure that the organization focuses its finite resources on its core mission activities and strategic arcs while improving the quality and breadth of products and services for physicians and medical students. Our physicians' and medical students' presence and voice are central to the overall success of our AMA.

The following pages discuss the 2021 consolidated results from operations, financial position and cash flows, as compared to 2020. Additional detailed discussion of operating unit results is included in the section titled "Group Operating Results."

Consolidated financial results

Results from operations

Net operating results

(in millions)

As noted above, the freeze on hiring and lack of travel and meetings and closed offices again reduced spending in 2021, while at the same time, revenue rose by over six percent, driving AMA's net operating income to $77.9 million. AMA does not expect to continue the limitations on spending throughout 2022 and future results are expected to be more modest.

In 2019, the AMA finalized termination of its defined benefit pension plan, providing lump sum payments to individuals that elected that option and purchasing a group annuity plan for participants that chose to remain in the plan. AMA recorded a $38.2 million noncash reclassification of prior actuarial losses from non-operating expense to operating expense, titled pension termination expense, as well as reclassifying a $2 million noncash tax benefit to income tax expense that was previously reported as a non-operating credit.

Excluding the $36.2 million noncash pension termination expense (net of the $2 million tax credit), AMA would have reported $23.4 million in net operating income for 2019.

Results discussed below reflect AMA's actual results from operations in 2021 as compared to 2020. Any pro forma charts exclude the impact of the pension termination on 2019 results.

Revenues

In 2021, total revenue improved by $26.3 million over the prior year, due to continued growth in AMA's royalties, as well as journal advertising, site licensing and open access fees. Coding book sales declined slightly during 2021, as AMA exited the retail coding book business, with all future sales going through third party distributors.

Consolidated investment income, which is dividend and interest income, net of management fees, was largely unchanged with higher dividend income offset by higher management fees due to growth in the portfolio size. Market gains or losses are not included in investment income and are reported as non-operating results.

The number of AMA dues paying members increased in 2021 by 2.7 percent, achieving 11 years of consecutive growth in membership. Over that period, AMA dues paying members increased by over 75,000.

Although increases occurred in lower dues paying categories such as group memberships and sponsored memberships, dues revenue rose by over 1 percent in 2021.

Cost of products sold and selling expenses

All variable expenses related to the production, distribution and sale of periodicals, books, coding products and licensed products are included in the cost of products sold and selling expense categories. Examples include paper, sales commissions, promotional activities, distribution costs and third-party editorial costs.

In 2021, cost of products sold and selling expenses decreased $3.4 million from the prior year, with reductions in coding book production costs and promotional expenses, as well as the absence of $1.6 million in production costs on a large contract in Health2047 for custom applications completed in 2020.

Contribution to general and administrative expenses

Cost of products sold and selling expenses are deducted from revenues to determine the amount of money available for the general and administrative expenses of the organization. Contribution to general and administrative expenses measures the gross margin derived from revenue-producing activities.

The contribution to general and administrative expenses increased $29.7 million to $433.8 million in 2021, with revenue improvements from royalties and journal publishing accounting for most of the change.

Pro forma general and administrative expenses

(in millions)

**Excluding the $36.2 million non-cash pension termination charge*

General and administrative expenses rose only $10.2 million in 2021, or 3 percent, when compared to 2020. This was substantially less than the $47 million budgeted increase for 2021, due to nonrecurring savings related to staffing, travel, office expenses and deferred programmatic activities. The last was largely due to work with health care systems, where capacity was severely strained by the pandemic.

Compensation and benefits increased $15.9 million, or approximately 7 percent. Compensation, including temporary help, was $8.6 million higher in 2021, a 4 percent increase. Fringe benefit costs increased $5.3 million in total, mainly due to higher medical costs, payroll taxes and employer 401k contributions. Limited utilization of healthcare during 2020 drove the prior year's costs down well below normal levels. Higher incentive compensation accounted for $1.1 million of the increase in compensation and benefits as the salary base increased and key performance indicators were achieved in 2021. Recruiting costs also increased after a large decline in 2020 due to the freeze on hiring during the initial pandemic year.

Occupancy costs were unchanged as AMA continued to experience reduced operating costs resulting from closing the office buildings in Chicago and Washington, D.C. during the pandemic.

Travel and meeting costs dropped by $0.5 million in 2021, after a $13.9 million decrease in 2020, again due to the pandemic restrictions.

Technology costs were up $2 million in 2021, largely related to continued development of the AMA Ed Hub and implementation of the Insurance Agency's new policy administration system.

Marketing and promotion costs rose $0.6 million in 2021, mainly focused on membership. Some of the increase is due to a reduced level of solicitation in 2020 during the initial months of the pandemic, as AMA chose to avoid marketing memberships to an overwhelmed healthcare system.

Outside professional services declined $1.4 million in 2021, with Health2047 reducing its use of outside management consultants.

A $6.4 million decrease in other operating expenses was driven by a decline in the Joy in Medicine Recognition programs as well as the cessation of a prior long-term grant program. The absence of a 2020 reserve for lease tax assessed by the City of Chicago on hosted solutions used by AMA was also a large factor in the overall decrease in this category.

Operating results before income taxes

The AMA reported $81.5 million in pre-tax operating income in 2021. That compares to $62 million in 2020, with substantially reduced expenses in both years due to pandemic restrictions on travel and meetings, staffing freezes and tight labor markets. A $26.3 million increase in revenue, coupled with lower product and selling costs, was only partially reduced by the general and administrative expense increases described above.

Income taxes

Taxes decreased $2.4 million in 2021 when compared to 2020, reflecting a reversal of reserves previously established for taxes and currently deemed unnecessary due to completion of tax audits, as well as lower taxable income in the taxable subsidiaries.

Net operating results

Net operating income was $77.9 million in 2021 compared to $56 million in 2020, driven mainly by improved revenues net of small expense increases.

Non-operating items

The AMA reported an $82.8 million gain in the fair value of its portfolio during 2021 after a $58.4 million gain in 2020.

As a result of an accounting standard adopted in 2019 for postretirement benefit plans, non-operating results include $3.9 million and $2.5 million in postretirement plan interest expense, recognized actuarial losses and prior service credits for 2021 and 2020, respectively.

Revenue in excess of (less than) expenses

Revenues exceeded expenses by $157.4 million in 2021, a combination of $77.9 million in operating income, the $82.8 million gain in fair value in the portfolio and

$3.3 million in other non-operating expenses. Revenues exceeded expenses by $112.1 million in 2020, a combination of $56 million in operating income, the $58.4 million gain in fair value in the portfolio and $2.3 million in other non-operating expenses.

Change in total association equity

(in millions)

Accounting standards require organizations to recognize deferred actuarial losses and prior service credits or charges for defined benefit postretirement plans as a charge or credit to equity.

In 2021, AMA recorded a $5.6 million credit to equity reflecting an actuarial gain for the postretirement healthcare plan, net of a reclassification of actuarial losses and prior service credits for the plan to operating expense. The gain resulted from higher interest rates and changes in participants, offset by an increase in baseline claims costs.

In 2020, AMA recorded a $2.8 million charge to equity reflecting an increase in actuarial losses for the postretirement healthcare plan and a reclassification of prior service credits for the plan to operating expense.

The AMA reported a $162.9 million increase in association equity in 2021. This reflects the amount by which revenues exceeded expenses, plus the credit to equity for changes in defined benefit postretirement plans discussed above, as well as a small decrease in donor-restricted equity.

The AMA reported a $107.8 million increase in association equity in 2020. This reflects the amount by which revenues exceeded expenses, less the charge to equity for changes in defined benefit postretirement plans discussed above, as well as a $1.5 million decrease in donor-restricted equity due to release of previously restricted funds.

Financial position and cash flows

The AMA's assets include cash, cash equivalents and investments; operating assets such as accounts receivable, inventory and prepaid expenses; fixed capital such as equipment, computer hardware and software; and other assets. AMA assets are supported by association equity, operating liabilities and deferred revenue.

Assets

(in millions)

The AMA's total assets increased $155.3 million in 2021. This includes a $149.5 million increase in cash and investments resulting from $73 million in free cash flow and an $82.8 million gain in the fair value of investment securities, minus $6.3 million for investments in affiliates.

Fiduciary funds are premium payments from insurance customers not yet remitted to the carriers and funds held by the AMA for third parties for future use as approved by the third parties. This approximates the offsetting liability titled insurance premiums and other fiduciary funds payable.

Operating assets increased $13.1 million in 2021, primarily due to an increase in accounts receivable and prepaid expenses. Changes in operating assets from year to year are largely due to timing of cash flows.

Other assets includes operating lease right-of-use assets, property and equipment and investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Operating lease right-of-use assets decreased due to amortization of the asset over the life of the lease. Property and equipment net book value also decreased as new capital spending was exceeded by annual depreciation and amortization of existing capital assets.

Operating liabilities decreased $6.2 million in 2021, as decreases in the postretirement health care plan liabilities, lease liability and income taxes payable were partially offset by increases in accounts payable, accrued expenses and other liabilities as well as accrued payroll and employee benefits.

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

Cash flows

Cash, cash equivalents and donor-restricted cash decreased $2.9 million in 2021 and increased $4.1 million in 2020. This comparison may cause misleading conclusions, as the change in cash and cash equivalents includes reductions for amounts invested in marketable securities, as well as cash inflows from non-operating activities.

Free cash

(in millions)

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

Free cash in 2021 totaled $73 million, substantially higher than the 2020 results, driven by a $19.6 million increase in cash from operations and lower capital spending. The increase in cash from operations was mainly due to improved operating results.

Reserve portfolios

Reserves

(in millions)

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

As of year-end 2021, the reserve portfolio's value was $887.6 million compared to $748.7 million in 2020, a $138.9 million increase. That increase was mainly the result of an $84.3 million gain in the fair value of the reserve portfolios plus a $54.2 million transfer of 2020 excess operating funds to reserves. Operating funds totaled $112.6 million in 2021, up $4.9 million from 2020.

The AMA has established a required minimum reserve investment portfolio level that is adequate to cover 100 percent of annual general and administrative expenses (excluding grant expenses) plus an amount sufficient to pay long-term postretirement and lease liabilities (net of the right-of-use asset value). Operating funds, coupled with operating assets, are to be maintained at a level that allows payment of all operating liabilities.

The minimum reserve portfolio level is designed to ensure that the AMA can always meet its long-term obligation for postretirement health care, as well as provide that the AMA could continue operations for at least one year in the case of a catastrophic occurrence.

Reserve portfolio funds also provide the AMA with the ability to fund major strategic spending initiatives not within the operating budget. Spending from the reserve funds is limited to the amount by which reserves exceed the minimum requirement. The Board of Trustees must authorize any use of reserves.

Permanent reserves and minimum reserve requirement

(in millions)

Group operating results

The AMA is organized into various operating groups: Membership, Publishing, Health Solutions & Insurance, Strategic Arcs & Core Mission Activities, Administration and Operations, Affiliated Organizations, Unallocated Overhead and Health2047 (including subsidiaries). Revenues and expenses directly attributed to those units are included in the group operating results. A financial summary of group operating results is presented at the end of this section. Prior year financial results have been restated to be consistent with the current year reported results for each group.

Contribution margin (net expenses)

Contribution margin equals individual group revenues minus cost of products sold, selling expenses, and direct general and administrative expenses such as compensation, occupancy, travel and meetings, technology costs and professional services.

Net expenses equals total spending, net of any revenue produced by the group, such as grants or other fee income. Total contribution margin and net expenses equals consolidated operating results before income taxes. The charts below separate groups with contribution margin from groups with net expenses.

Contribution margin

(in millions)

The contribution margin generated by Membership, Publishing, Health Solutions & Insurance, as well as Investments, provides the funding for all mission-related activities of the AMA as well as funding for all administration and support operations required to run the organization.

Membership

The Membership group's total revenue includes both net membership dues and interest expense on lifetime memberships. Net membership dues include the gross dues revenue collected, reduced by any commissions paid to state societies, and equal the membership dues revenue reported on the statement of activities.

The AMA achieved its eleventh consecutive year of increases in the number of dues-paying members, with dues revenue also increasing. The number of dues paying members increased 2.7 percent and total membership increased 2.3 percent in 2021. Membership growth in 2021 was favorably impacted by expanding use of digital tools to more effectively engage physicians and retain them as lifelong members; group membership marketing; and expanding AMA's reach to physicians through programmatic activities.

Dues revenue was $34.8 million, a $0.4 million increase from 2020. Interest expense on lifetime memberships was zero in 2021 and $0.1 million in 2020.

Membership's contribution margin decreased $0.5 million in 2021 with higher costs resulting from a return to normal marketing efforts, partially offset by the dues revenue improvement. In 2020, AMA had ceased soliciting physician memberships during the first few months of the pandemic.

Publishing, Health Solutions & Insurance

Publications in the JAMA Network include the *Journal of the American Medical Association (JAMA)* and the JAMA Network specialty journals. In recent years, the JAMA Network has launched four new journals: *JAMA Oncology* in 2015 and *JAMA Cardiology* in 2016, which are hybrid journals offering open access options for research articles; *JAMA Network Open* in 2018, a fully open access journal; and *JAMA Health Forum* in 2021, a peer-reviewed, open-access, online journal focused on health policy, health care systems, and global and public health.

Publishing revenues are derived from advertising, subscriptions, site licensing, reprints, electronic licensing, open access fees and royalties. Publishing revenues increased $2.8 million in 2021, with growth in print advertising, journal site licensing and open access fees. Expenses rose $3.6 million during 2021, primarily in compensation and benefits, with two-thirds of that increase in editorial operations. The contribution margin thus declined by $0.8 million to $9.1 million.

Health Solutions includes two major lines: Database Products, and Books and Digital Content.

Database Products includes royalties from licensed data sales and credentialing products revenue. Revenues increased in 2021, up $3.7 million when compared to 2020, driven in large part by new customer contracts. Expenses were down $0.6 million due to the absence of costs for the new technology platform incurred in early 2020. The resulting contribution margin rose by $4.3 million in 2021.

AMA-published books and coding products, such as CPT books, workshops and licensed data files, make up the Books and Digital Content unit. Revenues in this unit increased by $21.8 million. Royalties and digital content sales drove this increase, as the market for electronic use of digital coding products continues to expand. A change in the pricing models and phasing in previous pricing models' changes were also key factors. Coding book sales declined slightly in 2021 as the move from print products to digital continues to adversely impact print product sales. AMA exited the retail print book business in mid-2021, with a limited impact on revenue. Expenses were down slightly in 2021, driven by reduced production and promotional costs. The contribution margin increased by $22.5 million to $209.2 million.

The AMA has two active for-profit subsidiaries, the AMA Insurance Agency (Insurance Agency) and Health2047. The latter is discussed separately at the end of this discussion and analysis.

The Insurance Agency revenues declined by $1.8 million in 2021, mainly due to a second decrease in commission rates to protect the viability of the plan, which allowed the Agency to avoid charging higher premiums to physician customers. The Insurance Agency, as broker, receives a commission on insurance policies sold. Expenses were largely unchanged from 2020 and the contribution margin declined to $20 million from $21.9 million in the prior year.

Other business operations net expenses were up slightly in 2021.

In total, Publishing, Health Solutions & Insurance contribution margin was $287.5 million, up $24 million in 2021.

Investments (AMA-only)

AMA-only investment income includes dividend and interest earnings on the AMA's portfolio. Investment income in AMA's active subsidiaries is included as part of the group results for Publishing, Health Solutions & Insurance and Health2047.

Investments' revenue was $11.3 million in 2021, a $0.1 million decrease over the prior year. Dividend and interest income improved in 2021 but was offset by higher management fees due to the growth in the portfolio value. The contribution margin declined by $0.1 million as well.

The net gain or loss on the market value of investments is not included in operating results but reported as a non-operating item. This amount is in addition to the investment income discussed above. In 2021, AMA reported a net gain of $82.8 million, compared to a $58.4 million gain in 2020. The total investment return, including investment income, on the reserve portfolios was 12.3 percent. That compares to a composite benchmark index of 11.7 percent.

Net expenses

Strategic Arcs

(in millions)

The Strategic Arcs include direct costs associated with the groups for Improving Health Outcomes (IHO), Medical Education including Accelerating Change in Medical Education (ACE), the AMA Ed Hub and Professional Satisfaction and Practice Sustainability (PS2).

IHO focuses on confronting two of the nation's most prevalent issues: Cardiovascular disease and type-2 diabetes, setting a course of innovation and action aimed at reducing the disease and cost burden associated with these selected conditions.

To help prevent type-2 diabetes, the AMA and the Centers for Disease Control and Prevention (CDC) developed a toolkit to help health care teams screen, test and refer at risk patients to in-person or online diabetes prevention programs (DPPs).

The AMA has developed online tools and resources created using the latest evidence-based information to support physicians to help manage their patients' high blood pressure (BP). These resources are available to all physicians and health systems as part of Target: BP™, a national initiative co-led by the AMA and the American Heart Association which has positioned the initiative for national scaling and impact.

In 2021, the focus remained on hypertension and prediabetes outcome goals with groundwork for moving toward cardiovascular disease risk reduction pilots of cloud-based, M.A.P. BP (a three-step program that works to diagnose and manage patients with hypertension) dashboards for healthcare organizations, providing a visual representation of their performance on five key blood pressure metrics, including stratification by ethnicity, race, and gender. Progress continues on implementation of the M.A.P. BP program with healthcare organizations, touching over a hundred thousand patients in 2021: IHO emphasized self-measured blood pressure (SMBP) in light of COVID-19, with a focus on physician tools for effective SMBP. Net expenses increased slightly in 2021.

Advancing Professional Development includes Medical Education/ACE and the AMA Ed Hub.

While the undergraduate medical school consortium grants successfully concluded in 2018, all 32 consortium schools have continued collaboration and new schools have been added to the ACE Consortium each year through focused innovation grants. The consortium of schools has been substantially expanded and now acts as a learning collaborative so that best practices can be developed, shared and implemented in medical schools across the country.

In 2019, the methods and learning from the undergraduate consortium initiative were extended to a new multi-year grant program on graduate medical education, designed to improve the transition from undergraduate to graduate medical education and to maintain and reinforce the positive changes initiated by the undergraduate consortium work. The COVID-19 pandemic reduced the ability to ramp up the residency program as quickly as had been planned and slowed some collaborative efforts, but progress continued on engaging with the ACE community of innovation.

One of the key outcomes of the ACE consortium was the development of Health Systems Science, a foundational platform and framework for the study and understanding of how care is delivered, how health professionals work together to deliver that care, and how the health system can improve patient care and health care delivery. The AMA has created the Health Systems Science Scholars program to cultivate a national community of medical educators and health care leaders who will drive the necessary transformation to achieve improved patient experience, improved health populations and reduced cost of care. Medical Education is also responsible for defining or influencing standards for undergraduate, graduate and continuing medical education and providing support for the Council on Medical Education. There was only a small increase in net expenses during 2021, as travel and meeting costs were again limited.

The AMA Ed Hub, formally launched in 2018, is a platform providing physicians and other health care providers content and educational services that support lifelong professional development. The AMA Ed Hub has unified the AMA education portfolio and has piloted integration of external content providers, launched new content sets

and established internal development plans enterprise wide, including the Health Equity Education Center and the UME Curricular Enrichment Program. The Ed Hub also gives doctors and other health professionals a streamlined way to earn, track and report continuing medical education activities spanning clinical, practice transformation and professionalism topics. Net expenses were up $2 million in 2021 due largely to growth in staffing and enhancements to the technology platform.

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

The goals of this group are to promote successful models in both the public and private sectors. This includes expanding research of credible practice science, creating tools and other solutions to help guide physicians, care teams and health system leaders on developing and implementing strategies to optimize practice efficiencies, reduce burnout and improve professional well-being; ensuring the physician perspective is represented in the design, implementation and evaluation of new health care technologies; and shaping the evolution of payment models for sustainability and satisfaction.

In 2021, over 350,000 physicians and residents were impacted by PS2 efforts as measured by the number of physicians impacted by AMA organizational and COVID assessments in practices/departments/units participating in collaborative training efforts across topics; attendees at workshops, boot camps, webinars, or other training sessions; physicians in the Joy in Medicine Health System Recognition Program organizations; number of STEPS Forward users; and physician connections with tech companies via the Physician Innovation Network. In 2021, net expenses declined by $1.4 million. This is driven almost entirely by decreases in Practice Transformation Initiative grants, as the program will be redirected toward research in future years.

Core mission activities

(in millions)

Core Mission Activities includes six groups: Advocacy; Health, Science & Ethics; Center for Health Equity; Integrated Health Model Initiative (IHMI); Enterprise Communications; and Marketing & Member Experience (MMX).

Advocacy includes federal and state level advocacy to enact laws and advance regulations on issues important to patients and physicians; economic, statistical and market research to support advocacy efforts; political education for physicians; grassroots advocacy; and maintaining relations with the federation of medicine. Advocacy led the AMA's public sector response to the COVID-19 public health emergency, lobbying to hold physicians harmless from Merit-based Incentive Payment System (MIPS) penalties, doubling Medicare payments for the vaccine, pressing states to allocate vaccines to physician offices and promoting the use of the Defense Production Act to provide personal protective equipment. AMA successfully lobbied to avoid Medicare physician payment cuts, continued work on scope of practice with state medical societies, enacting legislation in several states to reduce the impact of prior authorization, while pressing for federal bicameral prior authorization legislation. In 2021, Advocacy net spending was largely unchanged with similar declines in travel and meetings and occupancy costs in the D.C. offices as had been experienced in 2020.

Health, Science & Ethics, is involved in developing AMA policies on scientific, public health and ethical issues for the House of Delegates (HOD); providing leadership, subject matter expertise and scientifically sound content and evidence that underpins and informs both current and future AMA initiatives in areas such as infectious disease, drug policy and opioid prescribing; overseeing maintenance of the AMA Code of Medical Ethics and publication of the *AMA Journal of Ethics*, AMA's online ethics journal;

and managing the United States Adopted Names (USAN) program, responsible for selecting generic names for drugs by establishing logical nomenclature classifications based on pharmacological or chemical relationships (reported separately in Group Operating Results). In 2020 and 2021, this group led the AMA's COVID-19 efforts by providing subject matter expertise and content, increased grant funding for public health-related work through a multi-million-dollar CDC grant, and developed and launched a strategic plan for precision medicine. Net expenses declined $1.3 million in 2021, due to the absence of a contribution made in 2020 for participating in a national campaign to provide science-based information on vaccines and cessation of multi-year grants to the Physician Consortium for Performance Improvement.

AMA recognized that a key to long-term success in our strategic arcs is increasing our efforts to reduce health and health care disparities. As a result of a 2018 task force report, the AMA sought leadership to embed health equity initiatives as relevant into all strategic priorities and areas of the organization, creating a new group, the Center for Health Equity (CHE). The focus of this newly created group is to elevate AMA's public role and responsibilities to improve health equity. In 2021, CHE released AMA's Strategic Plan to embed racial justice and advance health equity, developed the Principles for Equity Health Innovation, created a Medical Justice in Advocacy fellowship, and implemented CDC's grant to strengthen public health systems and services. During its second full year of operations, efforts focused on establishing an AMA presence in the health equity research literature that reflects our alliances with other organizations and external thought leaders; strengthening AMA assets into place-based community-driven efforts such as the collaborative on Chicago's west side called West Side United; building staff capacity to understand concepts surrounding health equity and to operationalize equity in goal and metric setting; and developing structural competency learning tools. The continued planned growth of CHE in 2021 resulted in a $6.1 million increase in net expenses.

IHMI brings together experts from patient care, medical terminology, and informatics around a common framework for defining and expressing health data. IHMI has been recognized as a leading authority on clinical content standards and is contributing to the development and use of clinical content through collaboration with Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR) , the Gravity Project and others. IHMI also provides technical and strategic capability to facilitate innovation within AMA via a repeatable and efficient path from ideation to market launch. In 2021, IHMI developed and matured social determinants of health (SDOH) and SMBP standards within HL7 and Standards Development Organizations (SDOs) and developed an SMBP software and services solution to pilot in 2022. IHMI net expenses were largely unchanged in 2021.

MMX extends the reach and impact of AMA's mission and advocacy initiatives and strengthens the AMA brand. MMX continues to take on increased oversight for managing the quality, timing and relevance of the experience physicians have at each point of interaction through AMA's digital publishing, health system engagement and member programs. MMX creates or packages AMA's content into digital formats and distributes AMA resources and thought leadership to intended audiences through owned and paid channels, raising awareness of AMA initiatives, resources and accomplishments and elevating the voice of AMA and physicians. In 2021, over 25 million unique individuals accessed AMA's website, a 10 percent increase over the record number of users in the prior year, which were driven by AMA's COVID-19 Resource Center and other compelling editorial, video, and social content developed during 2020 and enhanced in 2021. Net expenses declined $0.8 million in 2021, as media costs were lower than the initial response to the pandemic in 2020.

Ongoing responsibilities of the Enterprise Communications area include amplifying the work of individual operating units among their core audiences while providing consistency and alignment with the AMA narrative. Enterprise Communications distinctly communicates AMA's leading voice in science and evidence to embed equity, innovation, and advocacy across the AMA's strategic work throughout health care. Net expenses were unchanged in 2021.

Governance

Governance includes the Board of Trustees and Officer Services, the HOD, Sections and Special Constituencies & International units. The Board of Trustees unit includes costs related to governance activities as well as expenses associated with support of the Strategic Arcs and Core Mission Activities. The HOD, Sections and Special Constituencies & International unit includes costs associated with annual and interim meetings, groups and sections and other HOD activities, as well as costs associated with AMA's involvement in the World Medical Association. In 2021, Governance net spending was up $0.8 million, mainly for virtual meeting costs.

Administration and operations

(in millions)

These units provide administrative and operational support for Publishing & Health Solutions, Membership, Strategic Arcs and Core Activities, as well as other operating groups. Net expenses were up slightly in 2021, an increase of $2.9 million, including a substantial increase in outside legal fees in 2021. Information Technology costs declined, and the remaining units reported mainly inflationary cost increases.

Affiliated organizations

Affiliated Organizations represent either grant or in-kind service support provided by the AMA to other foundations and societies. In some cases, the AMA is reimbursed for services provided. No net expenses were reported in 2021.

Unallocated overhead

The net expenses in this area include costs not allocated back to operating units such as corporate insurance and actuarial services, employee incentive compensation, valuation allowances or other reserves. In 2021, these expenses totaled $29.5 million, down from $32.7 million in 2020. Higher incentive compensation reduced by the absence of a 2020 reserve for the Chicago lease tax on hosted solutions used by AMA were the main factors in the decrease.

Health2047 and subsidiaries

AMA has established a business formation and commercialization enterprise, designed to enhance AMA's ability to define, create, develop and launch, with partners, a portfolio of products and technologies that will have a profound impact on many aspects of the U.S. health care system and population health, with a central goal of helping physicians in practice. The Board approved the use of reserves to establish this subsidiary with plans to use third party resources to assist in funding spinoffs with commercial potential in future years.

Health2047 funds initial projects and moves those that demonstrate commercial appeal into separate companies, along with necessary seed funding for the new companies. After the initial stage, it is expected that these companies should command additional investment from third parties to begin commercialization of the product, either through debt or equity financing. At some point in the future, the spinoffs will be sold or liquidated, at which time, AMA would expect to receive a financial return.

Since 2017, Health2047 has spun off or invested in ten companies, Akiri, Inc. (Akiri), First Mile Care, Inc. (FMC), HXSquare, Inc. (HXS), Zing Health Enterprises, LP (Zing), Medcurio, Inc. (Medcurio), Phenomix Sciences Inc. (Phenomix), Sitebridge Research, Inc. (Sitebridge), Emergence Healthcare Group, Inc. (Emergence), Heal Security, Inc. (Heal) and Recovery Exploration Technologies, Inc. (RecoverX). Akiri and FMC are subsidiaries of Health2047 while the remaining eight entities are not wholly owned or controlled by Health2047 and therefore not consolidated.

Health2047 operating costs, as well as the two subsidiaries, Akiri and FMC, are included in the consolidated financial results reported herein. Health2047's proportionate share of net earnings or loss from four affiliated companies (HXSquare, Emergence, Heal and RecoverX) are reported as one line on AMA's financial statements and included in Health2047's operating results.

Health2047 has less than 20 percent interest in the four remaining companies (Zing, Medcurio, Phenomix and Sitebridge) and investments in these companies are carried at cost.

Third-party financing is expected to cover most long-term future costs for many of these companies.

Health2047 revenue in 2021 was $1 million, compared to $2.3 million in 2020. In 2020, Health2047 recognized revenue and associated costs for creating custom applications for a customer, with revenue of $2.6 million. Health2047 reflects its proportionate loss in earnings of affiliates as a contra revenue, totaling $0.6 million in both 2021 and 2020. Health2047 also has investment income in both years.

Expenses declined in 2021 by $2.7 million, of which $1.6 million related to the absence of 2020 costs for the custom applications and $1 million reflected reduced operating costs in Akiri. The cost reductions were partially offset by the revenue decline, with net expenses dropping by $1.4 million in 2021 to $11.3 million.

The summary of group operating results is included on the following page.

American Medical Association group operating results

(in millions)	Revenues 2021	Revenues 2020	Margin (expenses) 2021	Margin (expenses) 2020
Membership	**$ 34.8**	$ 34.3	**$ 16.3**	$ 16.8
Publishing, Health Solutions & Insurance				
Publishing	**67.7**	64.9	**9.1**	9.9
Database Products	**63.4**	59.7	**51.9**	47.6
Books and Digital Content	**233.5**	211.7	**209.2**	186.7
Insurance Agency/Affinity Products	**38.0**	39.8	**20.0**	21.9
Other business operations	**-**	-	**(2.7)**	(2.6)
	402.6	376.1	**287.5**	263.5
Investments (AMA-only)	**11.3**	11.4	**10.6**	10.7
Strategic Arcs & Core Mission Activities				
Improving Health Outcomes	**0.1**	0.1	**(14.7)**	(14.5)
Medical Education/Accelerating Change in Medical Education	**0.3**	0.2	**(12.4)**	(11.9)
Professional Satisfaction and Practice Sustainability	**0.4**	-	**(10.8)**	(12.2)
Integrated Health Model Initiative	**-**	-	**(5.1)**	(5.0)
Advocacy	**0.5**	2.1	**(25.5)**	(25.2)
Health, Science & Ethics	**2.5**	1.0	**(4.3)**	(5.6)
Center for Health Equity	**-**	0.2	**(10.0)**	(3.9)
AMA Ed Hub	**0.3**	0.2	**(9.6)**	(7.6)
Enterprise Communications	**-**	-	**(4.2)**	(4.2)
Marketing and Member Experience	**-**	-	**(15.8)**	(16.6)
United States Adopted Names Program	**4.0**	3.1	**3.3**	2.4
	8.1	6.9	**(109.1)**	(104.3)
Governance				
Board of Trustees and Officer Services	**-**	-	**(5.2)**	(4.9)
House of Delegates, Sections, Special Constituencies & International	**-**	-	**(5.7)**	(5.2)
	-	-	**(10.9)**	(10.1)
Administration and operations				
Information Technology	**-**	-	**(31.3)**	(32.3)
Senior Executive Management	**-**	-	**(4.7)**	(4.5)
General Counsel	**-**	-	**(8.3)**	(6.7)
Finance & Risk Management	**-**	-	**(7.8)**	(7.0)
Human Resources	**-**	-	**(7.1)**	(6.3)
Corporate Services	**-**	-	**(5.4)**	(5.5)
Customer Service	**-**	-	**(3.4)**	(3.2)
Strategic Insights and Planning	**-**	-	**(4.1)**	(3.7)
	-	-	**(72.1)**	(69.2)
Affiliated Organizations	**0.1**	0.1	**-**	-
Unallocated Overhead	**1.8**	2.3	**(29.5)**	(32.7)
Health2047 & Subsidiaries	**1.0**	2.3	**(11.3)**	(12.7)
Consolidated revenue and income before tax	**$ 459.7**	$ 433.4	**81.5**	62.0
Income taxes			**(3.6)**	(6.0)
Consolidated net operating income			**$ 77.9**	$ 56.0

CONSOLIDATED FINANCIAL STATEMENTS

American Medical Association and subsidiaries

Consolidated statements of activities

Years ended December 31

(in millions)	2021	2020
Revenues		
Membership dues	$ 34.8	$ 34.4
Advertising	14.4	13.6
Journal print subscription revenues	3.3	3.7
Journal online revenues	31.2	29.8
Other publishing revenue	18.0	16.9
Books, newsletters and online product sales	25.5	25.7
Royalties and credentialing products	270.5	245.1
Insurance commissions	35.0	36.7
Investment income (Note 4)	11.6	11.6
Equity in losses of affiliates (Note 2)	(0.6)	(0.6)
Grants and other income	16.0	16.5
Total revenues	**459.7**	**433.4**
Expenses		
Cost of products sold and selling expenses	25.9	29.3
Contribution to general and administrative expenses	**433.8**	**404.1**
General and administrative expenses		
Compensation and benefits	233.3	217.4
Occupancy	21.1	21.1
Travel and meetings	3.6	4.1
Technology costs	28.0	26.0
Marketing and promotion	18.1	17.5
Professional services	28.7	30.1
Other operating expenses	19.5	25.9
Total general and administrative expenses	**352.3**	**342.1**
Operating results before income taxes	81.5	62.0
Income taxes (Note 9)	3.6	6.0
Net operating results	**77.9**	**56.0**
Non-operating items		
Net gain on investments (Note 4)	82.8	58.4
Defined benefit postretirement plan non-service periodic expense (Note 8)	(3.9)	(2.5)
Other	0.6	0.2
Total non-operating items	**79.5**	**56.1**
Revenues in excess of expenses	**157.4**	**112.1**
Changes in defined benefit postretirement plans, other than periodic expense, net of tax (Notes 8 and 9)	5.6	(2.8)
Change in association equity	**163.0**	**109.3**
Change in donor restricted association equity		
Restricted contributions	0.3	0.3
Net assets released from restriction	(0.4)	(1.8)
Change in association equity – donor restricted	**(0.1)**	**(1.5)**
Change in total association equity	**162.9**	**107.8**
Total association equity at beginning of year	732.0	624.2
Total association equity at end of year	**$ 894.9**	**$ 732.0**

See accompanying notes to the consolidated financial statements.

American Medical Association and subsidiaries

Consolidated statements of financial position

As of December 31

(in millions)	2021	2020
Assets		
Cash, cash equivalents and donor-restricted cash	$ 32.1	$ 35.0
Fiduciary funds (Note 2)	22.5	21.4
Investments in affiliates (Note 2)	7.0	1.0
Accounts receivable and other receivables, net of an allowance for doubtful accounts of $0.2 in 2021 and $0.4 in 2020	88.5	82.8
Inventories	1.7	2.3
Prepaid expenses and deposits	13.0	10.8
Deferred income taxes (Note 9)	4.7	4.9
Investments (Note 4)	1,006.6	854.2
Property and equipment, net (Note 6)	39.6	43.3
Operating lease right-of-use assets (Note 10)	46.0	52.0
Other assets (Note 5)	9.4	8.1
	$1,271.1	**$1,115.8**
Liabilities, deferred revenue and association equity		
Liabilities		
Accounts payable, accrued expenses and other liabilities	$ 18.6	$ 17.4
Accrued payroll and employee benefits (Note 7)	54.6	48.8
Accrued postretirement healthcare benefits (Note 8)	117.5	120.5
Insurance premiums and other fiduciary funds payable	22.4	21.5
Income taxes payable (Note 9)	-	2.1
Operating lease liability (Note 10)	76.7	85.7
	289.8	296.0
Deferred revenue		
Membership dues	14.6	16.4
Subscriptions, licensing, insurance commissions and royalties	69.4	68.4
Grants and other	2.4	3.0
	86.4	87.8
Association equity	894.9	731.9
Donor-restricted association equity	-	0.1
Total association equity	894.9	732.0
	$1,271.1	**$1,115.8**

See accompanying notes to the consolidated financial statements.

American Medical Association and subsidiaries

Consolidated statements of cash flows

Years ended December 31

(in millions)	2021	2020
Cash flows from operating activities		
Change in total association equity	$ 162.9	$ 107.8
Adjustments to reconcile change in association equity to net cash provided by operating activities		
Depreciation and amortization	12.3	12.6
Postretirement health care expense	5.3	4.0
Noncash operating lease expense	10.1	10.0
Net gain on investments	(82.8)	(58.4)
Equity in losses of affiliates	0.6	0.6
Noncash (credit) charge for changes in defined benefit plans other than periodic expense net of tax	(5.6)	2.8
Bad debt expense	(0.2)	0.1
Other	(1.1)	(0.1)
Changes in assets and liabilities		
Accounts receivable and other receivables	(5.5)	(15.2)
Inventories	0.6	0.4
Prepaid expenses and deposits	(1.8)	(1.9)
Other assets	-	1.6
Accounts payable, accrued liabilities and income taxes payable	(9.4)	(4.7)
Accrued postretirement benefit costs	(2.4)	(1.7)
Deferred revenue	(1.4)	4.1
Net cash provided by operating activities	81.6	62.0
Cash flows from investing activities		
Purchase of property and equipment	(8.6)	(11.0)
Investment in affiliates	(6.3)	(1.5)
Purchase of investments	(662.6)	(636.9)
Proceeds from sale of investments	593.0	591.5
Net cash used in investing activities	(84.5)	(57.9)
Net change in cash, cash equivalents and donor restricted cash	**(2.9)**	**4.1**
Cash, cash equivalents and donor restricted cash at beginning of year	35.0	30.9
Cash, cash equivalents and donor restricted cash at end of year	**$ 32.1**	**$ 35.0**
Noncash investing activities		
Noncash exchange of convertible debt for investment in affiliate (Note 2)	$ -	$ 1.7
Accounts payable for property and equipment additions	$ 0.9	$ 0.9

See accompanying notes to the consolidated financial statements.

Notes to financial statements

For the years ended December 31, 2021 and 2020
(Columnar amounts in millions)

1. Nature of operations

The American Medical Association (AMA) is a national professional association of physicians with approximately 278 thousand members. The AMA serves the medical community and the public through standard setting and implementation in the areas of science, medical education, improving health outcomes, health equity, delivery and payment systems, ethics, representation and advocacy, policy development, and image and identity building. The AMA provides information and services to hundreds of thousands of physicians and includes journal and book publishing, physician credentialing, database licensing, insurance and other professional services for physicians.

The AMA classifies all operating results as revenues and expenses in the consolidated statements of activities. Non-operating items include net realized and unrealized gains and losses on investments, defined benefit postretirement plan non-service expense and other non-recurring income or expense.

Donor-restricted association equity includes contributions restricted for use for scope of practice which are not available for general use by AMA.

2. Significant accounting policies

Consolidation policy

The accompanying consolidated financial statements include the accounts of the AMA and its subsidiaries, AMA Services, Inc., American Medical Assurance Company and Health2047 Inc. (collectively, the AMA).

AMA, through its wholly owned subsidiary, Health2047 has investments in eight companies or limited partnerships. The equity method of accounting is used to account for investments in companies in which the AMA has significant influence but not overall control. The investments are initially recorded at the original amounts paid for common and convertible preferred stock, and subsequently adjusted for the AMA's share of undistributed earnings and losses from the underlying entities from the dates of formation. The investment will be increased or reduced by any future additional contributions and distributions received, respectively. The cost method of accounting is used to account for investments in companies in which the AMA has neither significant influence nor overall control and where the fair value is not readily determinable.

The companies accounted for under the equity method of accounting in 2021 are: HXSquare, Inc., formed in January 2019, Phenomix Sciences Inc. (previously named Health2047 Spinout Corporation), formed August 2020, Emergence Healthcare Group, Inc. (Emergence), formed January 2021, Heal Security, Inc. formed in February 2021, and Recovery Exploration Technologies, Inc., formed August 2021. During 2021, the AMA ceased application of the equity method to account for the investment in Phenomix Sciences Inc. as additional third-party investment resulted in AMA no longer exercising significant influence over this entity.

At December 31, 2021 AMA ownership interest is 20% in HXSquare, Inc., 21.9% in Emergence Healthcare Group, Inc., 33.3% in Heal Security, Inc. and 22.6% in Recovery Exploration Technologies, Inc. At the end of 2021, the book value of the four investments accounted for under the equity method, net of convertible debt, is $2.4 million.

In addition, at December 31, 2021, AMA has an ownership interest of 5.5% in Zing Health Enterprises, LP, 11.8% in Medcurio Inc. (formed February 2020), 14.4% in Phenomix Sciences, Inc. and 18.8% in Sitebridge Research, Inc. (formed January 2021). The investments in these entities are accounted for using the cost method, as AMA holds less than a 20% ownership and does not exercise significant influence over the entities. The book value of the four investments carried at cost at December 31, 2021 is $4.6 million.

Health2047 had investments in four companies or limited partnerships as of December 31, 2020. The companies accounted for under the equity method of accounting in 2020 are: HXSquare, Inc., Zing Health Holdings, Inc. and Health2047 Spinout Corporation. During 2020, the AMA ceased application of the equity method to account for investments in Zing Health Holdings, Inc. and Medcurio Inc. as additional third-party investment in these entities reduced AMA's ownership and holding in convertible debt of Zing Health Holdings, Inc. was converted to Class B shares in the limited partnership. This resulted in AMA no longer exercising significant influence over this entity.

At December 31, 2020, AMA ownership interest was 35.1% in HXSquare, Inc., and 28.9% in Health2047 Spinout Corporation. At the end of 2020, the book value of the two investments accounted for under the equity method, net of convertible debt, was approximately zero.

In addition, at December 31, 2020, AMA had an ownership interest of 14.1% in Zing and 11.8% in Medcurio. The investments in these entities were accounted for using the cost method, as AMA held less than a 20% ownership and did not exercise significant influence over the entities. The book value of the two investments carried at cost at December 31, 2020 was approximately zero.

Use of estimates

Preparation of consolidated financial statements in conformity with accounting principles generally accepted (GAAP) in the United States of America requires management to make estimates and assumptions that affect reported amounts of assets, liabilities, revenues and expenses as reflected in the consolidated financial statements. Actual results could differ from estimates.

Cash equivalents

Cash equivalents consist of liquid investments with original maturities of three months or less and are recorded at cost, which approximates fair value.

Fiduciary funds

One of the AMA's subsidiaries, the AMA Insurance Agency, Inc. (Agency), in its capacity as an insurance broker, collects premiums from the insured and, after deducting its commission, remits the premiums to the underwriter of the insurance coverage. Unremitted insurance premiums are invested on a short-term basis and are held in a fiduciary capacity. The AMA also collects and holds contributions on behalf of a separate unincorporated entity with $2.8 million and $2.7 million held at December 31, 2021 and 2020, respectively.

Inventories

Inventories, consisting primarily of books and paper for publications, are valued at the lower of cost or net realizable value.

Property and equipment

Property and equipment are carried at cost, less accumulated depreciation and amortization. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the assets. Equipment and software are depreciated or amortized over three to 10 years. Leasehold improvements are depreciated over the shorter of the estimated useful lives or the remaining lease term.

Revenue recognition

Revenue is recognized upon transfer of control of promised products or services to customers in an amount that reflects the consideration that AMA expects to receive in exchange for those products or services. AMA enters into contracts that generally include only one product or service and as such, are distinct and accounted for as separate performance obligations. Revenue is recognized net of allowances for returns and any taxes collected from customers, which are subsequently remitted to governmental authorities.

Nature of products and services

Membership dues are deferred and recognized as revenue in equal monthly amounts during the applicable membership year, which is a calendar year. Dues from lifetime memberships are recognized as revenue over the approximate life of the member.

Licensing and subscriptions to scientific journals, site licenses, newsletters or other online products are recognized as revenue ratably over the terms of the subscriptions or service period. Advertising revenue and direct publication costs are recognized in the period the related journal is issued. Book and product sales are recognized at the time the book or product is shipped or otherwise delivered to the customer. Royalties are recognized as revenue over the royalty term. Insurance brokerage commissions on individual policies are recognized as revenue on the date they become effective or are renewed, to the extent services under the policies are complete. Brokerage commissions or plan rebates on the group products are recognized as revenue ratably over the term of the contract as services are rendered.

Contract balances

AMA records a receivable when the performance obligation is satisfied and revenue is recognized. For agreements covering subscription or service periods, AMA generally records a receivable related to revenue recognized for the subscription, license or royalty period. For sales of books and products, AMA records a receivable at the time the product is shipped or made available. These amounts are included in accounts receivable on the consolidated statements of financial position and the balance, net of allowance for doubtful accounts, was $85.1 million and $77.7 million as of December 31, 2021 and 2020, respectively.

The allowance for doubtful accounts reflects AMA's best estimate of probable losses inherent in the accounts receivable balance. The allowance is based on historical experience and other currently available evidence.

Payment terms and conditions vary by contract type, although terms generally include a requirement of payment within 30 to 60 days. Some annual licensing agreements carry longer payment terms. In instances where the timing of revenue recognition differs from the timing of invoicing, AMA has determined that these contracts generally do not include a significant financing component.

Prepaid dues are included as deferred membership dues revenue in the consolidated statements of financial position. Prepayments by customers in advance of the subscription, royalty or insurance coverage period are recorded as deferred subscriptions, licensing, insurance commissions and royalty revenue in the consolidated statements of financial position.

Income taxes

The AMA is an exempt organization as defined by Section 501(c)(6) of the Internal Revenue Code and is subject to income taxes only on income determined to be unrelated business taxable income. The AMA's subsidiaries are taxable entities and are subject to income taxes.

3. New accounting standards update

In August 2018, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2018-14, *Compensation-Retirement Benefits-Defined Benefit Plans-General*. This requires sponsors of postretirement benefit plans to provide additional disclosures, including a narrative description of reasons for any significant gains or losses impacting the benefit obligation for the period, and eliminates certain previous disclosure requirements. The new guidance is effective for the AMA for the year ended December 31, 2022. AMA chose to early adopt this guidance effective December 31, 2021. The early adoption of this standard did not have a material impact on the AMA's consolidated financial statements.

In August 2020, FASB issued ASU No. 2020-06, *Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity's Own Equity (Subtopic 815-40)—Accounting for Convertible Instruments and Contracts in an Entity's Own Equity*. The amendments in this update are expected to improve, simplify, and enhance the financial reporting requirements for convertible instruments and contracts in an entity's own equity for all entities, including private companies. The new guidance is effective for the AMA for the year ending December 31, 2024. We do not expect there to be a material impact on AMA's consolidated financial statements upon adoption.

4. Investments

Investments include marketable securities and venture capital private equity investments that are carried at fair value.

In determining fair value, the AMA uses various valuation approaches. The FASB's Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures*, establishes a hierarchy for inputs used in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the most observable inputs be used when available. Observable inputs are inputs that market participants would use in pricing the asset based on market data obtained from sources independent of the organization. Unobservable inputs are inputs that would reflect an organization's assumptions about the assumptions market participants would use in pricing the asset developed based on the best information available in the circumstances. The hierarchy is broken down into three levels based on the observability of inputs as follows:

Level 1—Valuations based on quoted prices in active markets for identical assets that the organization has the ability to access. Since valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these products does not entail a significant degree of judgment.

Level 2—Valuations based on one or more quoted prices in markets that are not active or for which all significant inputs are observable, either directly or indirectly.

Level 3—Valuations based on inputs that are unobservable and significant to the overall fair value measurement.

The availability of observable inputs can vary from instrument to instrument and is affected by a wide variety of factors, including, for example, the liquidity of markets and other characteristics particular to the transaction. To the extent that valuation is based on models or inputs that are less observable or unobservable in the market, the determination of fair value requires more judgment.

The AMA uses prices and inputs that are current as of the measurement date, obtained through a third-party custodian from independent pricing services.

A description of the valuation techniques applied to the major categories of investments measured at fair value is outlined below.

Exchange-traded equity securities are valued based on quoted prices from the exchange. To the extent these securities are actively traded, valuation adjustments are not applied and they are categorized in Level 1 of the fair value hierarchy.

Mutual funds are open-ended Securities and Exchange Commission (SEC) registered investment funds with a daily net asset value (NAV). The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy.

The fair value of corporate debt securities is estimated using recently executed transactions, market price quotations (where observable) or bond spreads. If the spread data does not reference the issuer, then data that reference a comparable issuer are used. Corporate debt securities are generally categorized in Level 2 of the fair value hierarchy.

U.S. government agency securities consist of two categories of agency issued debt. Non-callable agency issued debt securities are generally valued using dealer quotes. Callable agency issued debt securities are valued by benchmarking model-derived prices to quoted market prices and trade data for identical or comparable securities. Agency issued debt securities are categorized in Level 2 of the fair value hierarchy.

U.S. government securities are valued using quoted prices provided by a vendor or broker-dealer. These securities are categorized in Level 2 of the fair value hierarchy, as it is difficult for the custodian to accurately assess at a security level whether a quoted trade on a bond represents an active market.

Foreign and U.S. state government securities are valued using quoted prices in active markets when available. To the extent quoted prices are not available, fair value is determined based on interest rate yield curves, cross-currency basis index spreads, and country credit spreads for structures similar to the bond in terms of issuer, maturity, and seniority. These investments are generally categorized in Level 2 of the fair value hierarchy.

Investments also include investments in a diversified closed end private equity fund with a focus on buyout and secondary market opportunities in the United States and the European Union, as well as investments in a venture capital fund focused on companies developing promising health care technologies that can be commercialized into revolutionary products and services that improve the practice of medicine and the delivery and management of health care. The investments are not redeemable and distributions are received through liquidation of the underlying assets of the funds. It is estimated that the underlying assets will be liquidated over the next four to ten years. The fair value estimates of these investments are based on NAV as provided by the investment manager. Unfunded commitments as of December 31, 2021, and 2020 totaled $76.4 million and $48 million, respectively.

The AMA manages its investments in accordance with Board-approved investment policies that establish investment objectives of real inflation-adjusted growth over the investment time horizon, with diversification to provide a balance between long-term growth objectives and potential liquidity needs.

The following table presents information about the AMA's investments measured at fair value as of December 31. In accordance with ASC Subtopic 820-10, investments that are measured at fair value using the NAV per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated statements of financial position.

	2021	2020
Level 1 – Quoted prices in active market for identical securities		
Equity securities	$ 474.6	$ 415.2
Fixed-income mutual funds	48.9	19.5
	523.5	434.7
Level 2 – Significant other observable inputs		
Debt securities		
Corporate	116.0	105.7
U.S. government and federal agency	269.1	247.5
Foreign government	28.7	26.3
U.S. state government	0.2	0.2
	414.0	379.7
Level 3 – Significant unobservable inputs	-	-
Other investments measured at NAV – Private equity and venture capital funds	69.1	39.8
Investments	$ 1,006.6	$ 854.2

Interest and dividends are included in investment income as operating revenue while realized and unrealized gains and losses are included as a component of non-operating items.

Investment income consists of:

	2021	2020
Investment dividend and interest income	$ 15.1	$ 14.3
Management fees	(3.5)	(2.7)
	$ 11.6	$ 11.6

Non-operating items include:

	2021	2020
Realized gains (losses) on investments, net	$ 74.8	$ (1.9)
Unrealized gains on investments, net	8.0	60.3
	$ 82.8	$ 58.4

5. Other assets

Other assets include investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Mutual funds are open-ended SEC registered investment funds with a daily NAV. The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy. The investments totaled $9.4 million and $8.1 million as of December 31, 2021 and 2020, respectively.

6. Property and equipment

Property and equipment at December 31 consists of:

	2021	2020
Leasehold improvements	$ 38.7	$ 38.7
Furniture and office equipment	19.7	19.5
Information technology		
Hardware	13.5	12.6
Software	97.6	96.4
	169.5	167.2
Accumulated depreciation and amortization	(129.9)	(123.9)
	$ 39.6	$ 43.3

7. Retirement savings plans

The AMA has a 401(k) retirement and savings plan, which allows eligible employees to contribute up to 75 percent of their compensation annually, subject to Internal Revenue Service (IRS) limits. The AMA matches 100 percent of the first three percent and 50 percent of the next two percent of employee contributions. The AMA may, at its discretion, make additional contributions for any year in an amount up to two percent of the compensation for each eligible employee. Compensation is subject to IRS limits and excludes bonuses and severance pay. AMA matching and discretionary contribution expense totaled $7.9 million and $7.4 million in 2021 and 2020, respectively.

8. Postretirement health care benefits

The AMA provides health care benefits to retired employees who were employed on or prior to December 31, 2010. After that date, no individual can become a participant in the plan. Generally, qualified employees become eligible for these benefits if they retire in accordance with the plan provisions and are participating in the AMA medical plan at the time of their retirement. The AMA shares the cost of the retiree health care payments with retirees, paying approximately 60 to 80 percent of the expected benefit payments. The AMA has the right to modify or terminate the postretirement benefit plan at any time. Other employers participate in this plan and liabilities are allocated between the AMA and the other employers.

The AMA has applied for and received the federal subsidy to sponsors of retiree health care benefit plans that provides a prescription drug benefit that is actuarially equivalent to Medicare Part D under the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*. In accordance with ASC Topic 958-715, *Compensation-Retirement Benefits*, the AMA initially accounted for the subsidy as an actuarial experience gain to the accumulated postretirement benefit obligation.

The postretirement health care plan is unfunded. In accordance with ASC Topic 958-715, the AMA recognizes this liability in its consolidated statements of financial position.

The following reconciles the change in accumulated benefit obligation and the amounts included in the consolidated statements of financial position at December 31:

	2021	2020
Benefit obligation at beginning of year	$ 120.5	$ 115.4
Service cost	1.5	1.5
Interest cost	2.8	3.2
Benefits paid	(3.8)	(2.9)
Participant contributions	1.2	1.3
Federal subsidy	0.2	0.1
Actuarial (gain) loss	(4.9)	1.9
Accrued postretirement benefit costs	$ 117.5	$ 120.5

The postretirement health care plan accumulated losses and prior service credits not yet recognized as a component of periodic postretirement health care expense, but included as an accumulated charge or credit to equity as of December 31 are:

	2021	2020
Actuarial losses	$ 21.6	$ 27.8
Prior service credits	-	(0.3)
	$ 21.6	$ 27.5

Actuarial assumptions used in determining the accumulated benefit obligation at December 31 are:

	2021	2020
Discount rate	2.8%	2.5%
Initial health care cost trend	6.1%	5.64%
Ultimate health care cost trend	4.0%	4.5%
Year that the rate reaches the ultimate trend rate	2045	2038

AMA recognizes postretirement health care expense in its consolidated statements of activities. The service cost component is included as part of compensation and benefits expense and the other components of expense are recognized as a non-operating item:

	2021	2020
Service cost	$ 1.4	$ 1.5
Interest cost	2.8	3.2
Amortization of prior service credit	(0.3)	(0.7)
Amortization of actuarial loss	1.4	-
	$ 5.3	$ 4.0

Postretirement health care-related changes, other than periodic expense, that have been included as a charge or credit to unrestricted equity consist of:

	2021	2020
Actuarial gains (losses) arising during period	$ 4.8	$ (1.9)
Reclassification adjustment for recognition of actuarial losses	1.4	-
Reclassification adjustment for recognition of prior service credit	(0.3)	(0.7)
Change in unrestricted equity	$ 5.9	$ (2.6)

Actuarial assumptions used in determining postretirement health care expense are the same assumptions noted in the table above for determining the accumulated benefit obligation, except as follows:

	2021	2020
Discount rate	2.5%	3.3%
Initial health care cost trend	5.64%	5.84%

The following postretirement health care benefit payments are expected to be paid by the AMA, net of contributions by retirees and federal subsidies:

2022	$ 3.1
2023	3.4
2024	3.6
2025	3.9
2026	4.1
2027 – 2031	23.5

9. Income taxes

The provision for income taxes includes:

	2021	2020
Operating		
Current	$ 3.7	$ 6.2
Deferred	0.1	-
Valuation allowance	(0.2)	(0.2)
	3.6	6.0
Tax expense related to credits or charges to equity		
Deferred	0.3	0.2
	$ 3.9	$ 6.2

As prescribed under ASC Topic 740, *Income Taxes*, the AMA determines its provision for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for future tax effects of temporary differences between the consolidated financial statement carrying amounts of existing assets and liabilities and their respective tax basis.

The deferred tax benefit or charge from credits or charges to equity represents the estimated tax benefit from recording unrecognized actuarial losses and prior service credits for the postretirement health care plan, pursuant to ASC Topic 958-715.

Valuation allowances are provided to reduce deferred tax assets to an amount that is more likely than not to be realized. The AMA evaluates the likelihood of realizing its deferred tax assets by estimating sources of future taxable income and assessing whether or not it is likely that future taxable income will be adequate for the AMA to realize the deferred tax asset. The AMA established an initial valuation allowance in 2009 to reflect the fact that deferred tax assets include future expected benefits, largely related to retiree health care payments, that may not be deductible due to a projected lack of taxable advertising income in future years. Increases or decreases in deferred tax assets, where future benefits are considered unlikely, will result in an equal and offsetting change in the valuation reserve. If the AMA were to make a determination in future years that these deferred tax assets would be realized, the related valuation allowance would be reduced and a benefit to earnings recorded.

Deferred tax assets recognized in the consolidated statements of financial position at December 31 are:

	2021	2020
Benefit plans and compensation	$ 7.3	$ 7.7
Other	(0.1)	(0.1)
	7.2	7.6
Valuation allowance	(2.5)	(2.7)
	$ 4.7	$ 4.9

Cash payments for income taxes were $6.2 million and $4.9 million in 2021 and 2020, respectively, net of refunds.

10. Leases

AMA leases office space at a number of locations and the initial terms of the office leases range from five years to 15 years. Most leases have options to renew at then prevailing market rates. As any extension or renewal is at the sole discretion of AMA and at this date is not certain, the renewal options are not included in the calculation of the right-of-use (ROU) asset or lease liability. AMA also leases copiers and printers in several locations. All office and equipment leases are classified as operating leases.

Operating lease costs totaled $10.1 million in 2021 and $10 million in 2020. Cash paid for amounts included in the measurement of lease liabilities totaled $13.1 million in 2021 and $12.8 million in 2020.

The remaining weighted-average lease term is 7.1 years and 8 years as of December 31, 2021 and 2020, respectively. The weighted-average discount rate used for operating leases is 5% for both 2021 and 2020.

The maturity of lease liabilities as of December 31, 2021:

2022	$ 13.1
2023	12.8
2024	12.4
2025	12.5
2026	12.7
2027 and beyond	28.3
Total lease payments	91.8
Less imputed interest	(15.1)
Present value of lease obligations	$ 76.7

11. Financial asset availability and liquidity

AMA has a formal reserve policy that defines the reserve investment portfolios as pools of liquid net assets that can be accessed to mitigate the impact of undesirable financial events or to pursue opportunities of strategic importance that may arise, as well as provide a source of capital appreciation. The policy establishes minimum required dollar levels required to be held in the portfolios (defined as an amount equal to one-year's general and administrative operating expenses plus long-term liabilities). The policy also covers the use of dividend and interest income, establishes criteria for use of the funds and outlines the handling of excess operating funds on an annual basis.

Dividend and interest income generated from the reserve portfolios are transferred to operating funds monthly and used to fund operations. The formal reserve policy contemplates use of reserve portfolio funds for board approved time- or dollar-limited strategic outlays, to the extent that the reserve portfolio balances exceed the minimum amount established by policy. All surplus funds generated from operations annually (defined as operating cash plus other current assets minus current liabilities and deferred revenue at year end) are transferred to the reserve portfolios after year-end. The reserve policy does not cover the for-profit subsidiaries' activities.

AMA invests cash in excess of projected weekly requirements in short-term investments and money market funds. AMA does not maintain any credit facilities as the reserve portfolios provide ample protection against any liquidity needs.

The following reflects AMA's financial assets as of December 31 reduced by amounts not available for general use that have been set aside for long-term investing in the reserve investment portfolios or funds subject to donor restrictions. AMA's financial assets include cash, cash equivalents and donor restricted cash, short-term investments and long-term investments in the reserve portfolios.

	2021	2020
Financial assets	$ 1,038.7	$ 889.2
Less assets unavailable for general expenditures:		
Restricted by donor with purpose restrictions	-	(0.1)
Restricted by governing body primarily for long term investing or for governing body approved outlays	(887.6)	(748.7)
Financial assets available to meet cash needs for general expenditures within one year	$ 151.1	$ 140.4

In addition to financial assets available to meet general expenditures over the next 12 months, the AMA operates under a policy that requires an annual budget surplus, excluding time- or dollar-limited strategic expenditures approved by the board, and anticipates generating sufficient revenue to cover general ongoing expenditures on an annual basis.

12. Contingencies

In the opinion of management, there are no pending legal actions for which the ultimate liability will have a material effect on the equity of the AMA.

13. Subsequent events

ASC Topic 855, *Subsequent Events*, establishes general standards of accounting for and disclosure of events that occur after the consolidated balance sheet date but before consolidated financial statements are issued or are available to be issued.

For the year ended December 31, 2021, the AMA has evaluated all subsequent events through February 11, 2022, which is the date the consolidated financial statements were available to be issued, and concluded no additional subsequent events have occurred that would require recognition or disclosure in these consolidated financial statements that have not already been accounted for.

14. Functional expenses

The costs of providing program and other activities have been summarized on a functional basis in the consolidated statements of activities. Certain costs have been allocated among the Strategic Arcs and Core Mission Activities, Publishing, Health Solutions and Insurance, Membership and other supporting services.

The expenses that are allocated and the method of allocation include the following: fringe benefits based on percentage of compensation and occupancy based on square footage. All other expenses are direct expenses of each functional area.

	Membership	Publishing, Health Solutions and Insurance	Investments (AMA only)	Strategic Arcs and Core Mission Activities	Governance, Administration and Operations	Health2047 and Subsidiaries	Total
Cost of products sold and selling expense	$ -	$ 25.9	$ -	$ -	$ -	$ -	$ 25.9
Compensation and benefits	5.8	62.4	-	70.1	88.5	6.5	233.3
Occupancy	0.5	5.6	-	6.7	6.8	1.5	21.1
Travel and meetings	-	0.6	-	1.1	1.8	0.1	3.6
Technology costs	1.6	10.4	-	6.3	9.7	-	28.0
Marketing and promotion	9.6	0.4	-	7.5	0.1	0.5	18.1
Professional services	0.1	4.5	0.3	16.6	4.7	2.5	28.7
Other operating expense	0.9	5.3	0.4	8.9	2.8	1.2	19.5
2021 total expense	**$ 18.5**	**$ 115.1**	**$ 0.7**	**$ 117.2**	**$ 114.4**	**$ 12.3**	**$ 378.2**
Cost of products sold and selling expense	$ -	$ 27.7	$ -	$ -	$ -	$ 1.6	$ 29.3
Compensation and benefits	5.5	58.1	-	63.5	84.2	6.1	217.4
Occupancy	0.5	5.7	-	6.7	6.7	1.5	21.1
Travel and meetings	0.1	0.8	-	1.8	1.3	0.1	4.1
Technology costs	1.8	9.6	-	4.4	10.1	0.1	26.0
Marketing and promotion	8.4	0.5	-	7.8	0.2	0.6	17.5
Professional services	0.4	4.9	0.2	16.1	4.3	4.2	30.1
Other operating expense	0.8	5.3	0.5	10.9	7.6	0.8	25.9
2020 total expense	**$ 17.5**	**$ 112.6**	**$ 0.7**	**$ 111.2**	**$ 114.4**	**$ 15.0**	**$ 371.4**

INDEPENDENT AUDITORS' REPORT

The Board of Trustees of American Medical Association

Opinion

We have audited the accompanying consolidated financial statements of the American Medical Association (the "AMA") and subsidiaries, which comprise the consolidated statements of financial position as of December 31, 2021 and 2020, and the related consolidated statements of activities and of cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the AMA as of December 31, 2021 and 2020, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the AMA and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the AMA's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Deloitte & Touche LLP
Chicago, Illinois
February 11, 2022

Written statement of certification of chief executive officer and chief financial officer

The undersigned hereby certify that the information contained in the consolidated financial statements of the American Medical Association for the years ended December 31, 2021 and 2020 fairly present, in all material respects, the financial condition and the results of operations of the American Medical Association.

James L. Madara, MD
Executive Vice President and Chief Executive Officer

Denise M. Hagerty
Senior Vice President and Chief Financial Officer

February 11, 2022

OFFICERS AND TRUSTEES

2021–2022 AMA BOARD OF TRUSTEES AND EXECUTIVE LEADERSHIP

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Immediate Past President

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Speaker, AMA House of Delegates

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Michael Suk, MD, JD, MPH, MBA

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CEO and Executive Vice President

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Dr. Suk

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Note: Bobby Mukkamala, Chair, Sandra Adamson Fryhofer, Chair-Elect, and, Russ Kridel, Immediate Past Chair, serve on all committees, except where otherwise noted, as *ex-officio* members without vote. Gerald E. Harmon, President, serves on all committees as an *ex-officio* member with vote. President-Elect and Immediate Past President are invited to all committee meetings as a courtesy.

Gerald E. Harmon, MD

Jack Resneck Jr., MD

Susan R. Bailey, MD

Bruce A. Scott, MD

Lisa Bohman Egbert, MD

Bobby Mukkamala, MD

Sandra Adamson Fryhofer, MD

Russ Kridel, MD

Scott Ferguson, MD

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James L. Madara, MD

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 4-A-22

Subject: AMA 2023 Dues

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee F

Our American Medical Association (AMA) last raised its dues in 1994. AMA continues to invest in improving the value of membership. As our AMA's membership benefits portfolio is modified and enhanced, management will continuously evaluate dues pricing to ensure optimization of the membership value proposition.

RECOMMENDATION

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

(Directive to Take Action)

Fiscal Note: No significant fiscal impact.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-A-22

Subject: Procedure for Altering the Size or Composition of Section Governing Councils

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee F

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

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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. (Modify Bylaws)

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. (Directive to Take Action)

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. (Modify Bylaws)

Fiscal Note: Modest - between $1,000 - $5,000

REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-A-22

Subject: Language Proficiency Data of Physicians in the AMA Masterfile (Resolution 613-A-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee F

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

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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 survey[5] 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 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 the remainder of this report be filed.

Fiscal Note: No significant fiscal impact.

ENDNOTES

1. Email correspondence between Carol Brockman and Pilar Ortega, MD, on Feb 25, 2020.
2. Diamond LC, Luft HS, Sukyung C, Jacobs EA, "'Does this doctor speak my language?' Improving the characterization of Physician Non-English Language Skills," *Health Services Research,* 2012 Feb; 47(1 Pt 2): 556–569, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3393012/, accessed Feb 24, 2020.
3. Diamond L, Sukyung C, Ferguson W, Gonzalez J, Jacobs EA, and Gany F, "Relationship between self-assessment and tested non-English language proficiency among primary care providers," *Med Care,* 2014 May; 52(5): 435–438, https://www.ncbi.nlm.nih.gov/pubmed/24556893, accessed Feb 24, 2020.
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5. Physician survey page of the Medical Board of California government Web site, https://www.mbc.ca.gov/Licensees/License_Renewal/Physician_Survey.aspx, accessed Feb 25, 2020.
6. "Physicians and Surgeons by Languages Spoken and Practice Location," https://healthdata.gov/dataset/physicians-and-surgeons-languages-spoken-and-practice-location, accessed Feb 24, 2020.
7. CAQH Fact Sheet, https://www.caqh.org/sites/default/files/about/marketing/caqh-overview-fact-sheet.pdf, accessed Feb 26, 2020.

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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
0: No Proficiency Unable to function in the spoken language. Oral production is limited to occasional isolated words. Has essentially no communicative ability.		
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.	**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.	**Basic** I speak the language imperfectly and only to a limited degree and in limited situations. I have difficulty in or understanding extended conversations.
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.	**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.	**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.
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 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.	**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.	**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.

ILR (Base levels only)	Adapted ILR	AAMC AMCAS
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.	**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.	**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.
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.	**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.	**Native/Functionally Native** I converse easily and accurately in all types of situations. Native speakers may think that I am a native speaker, too.

APPENDIX B – RELATED AMA POLICIES AND STANDARDS

AMA Policy

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 identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.

(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.

(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.

(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 20-A-22

Subject: Delegate Apportionment and Pending Members

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee F

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

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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:

Year	Dues received	Member year	In apportionment?
Year 1	4th 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 year-end membership	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.[1]

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

[1] 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.)

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.

RECOMMENDATIONS

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

1. That pending members no longer be considered in apportioning delegates in the House of Delegates. (Directive to Take Action)

2. That delegate apportionment for 2023 for constituent societies be based on official 2022 year-end AMA membership data as recorded by the AMA. (Directive to Take Action)

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 for 2022 plus 5.

   (Directive to Take Action)

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. (Directive to Take Action)

6. That Policy G-600.016, “Data Used to Apportion Delegates,” be rescinded. (Rescind HOD Policy)

Fiscal Note: $1500

JOINT REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS AND THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CCB/CLRPD Report 1-A-22

Subject: Joint Council Sunset Review of 2012 House Policies

Presented by: Pino Colone, MD, Chair, Council on Constitution and Bylaws
Clarence Chou, MD, Chair, Council on Long Range Planning and Development

Referred to: Reference Committee F

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

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

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy (per Policy G-600.111(4), The consolidation process permits editorial amendments for the sake of clarity, so long as the proposed changes are transparent to the House and do not change the meaning); (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House to handle the sunset reports.

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

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

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

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

The Councils on Constitution and Bylaws and Long Range Planning and Development collaborated on this report, as they did the last time these policies were up for review.

RECOMMENDATION

The Councils on Constitution and Bylaws and Long Range Planning and Development recommend that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-155.998	Meeting with Business Coalitions	Our AMA: (1) shall continue to monitor the activities of business coalitions and other health care coalitions, ~~including The Leapfrog Group,~~ and keep physicians and the Federation of Medicine informed of the activities and new initiatives of these coalitions; (2) shall continue to meet with and serve with vigilance on appropriate advisory committees to national business and other health care coalitions~~,~~ ~~including The Leapfrog Group,~~ to establish a dialogue with these coalitions and provide physicians' unique clinical and patient-centered expertise in a manner consistent with AMA policy and sound quality and patient safety principles; (3) shall encourage the other members of the Federation of Medicine to meet with and serve on appropriate advisory committees to business and other health care coalitions in their geographic area or field of medical specialization to establish a dialogue with these coalitions and provide physicians' unique clinical and patient-centered expertise in a manner consistent with sound quality and patient safety principles and keep the AMA informed of the results of these activities; (4) continue to promote its policies regarding the proper collection and use of physician and hospital quality data; (5) shall advocate that business and health care coalitions, and other similar entities be reminded that The Joint Commission ~~the JCAHO~~ standards, as well as most state hospital licensure laws, require that the advice and approval of the hospital medical staff or medical groups must be sought before clinical practices are modified; (6) shall actively address with business and health care coalitions, as well as with other similar entities, the problems of delivering quality care that are created by under-reimbursement of health care services by third party payers; and (7) shall exercise extreme caution when meeting with ~~The Leapfrog Group and other~~ business coalitions to avoid implied and unintended concurrence with the recommendations of such groups.	Retain as editorially amended: It is unnecessary to reference The Leapfrog Group; the Joint Commission is the new name for the organization formerly called JCAHO.

D-165.975	Health Care for the Economically Disadvantaged	Our AMA shall continue in its efforts to highlight the need for improved access to quality health care for the disadvantaged, working with the private sector and government at all levels to improve access for this population.	Rescind. This policy has been superseded by more recent policies and directives that commit our AMA to improving health care for all, including the economically disadvantaged. Policies include H-410.995, Participation in the Development of Practice Guidelines by Individuals Experienced in the Care of Minority and Indigent Patients, H-160.922, Physician and Health Plan Provision of Uncompensated Care; H-185.917, Reducing Inequities and Improving Access to Insurance for Maternal Health Care, H-180.978, Access to Affordable Health Care Insurance through Deregulation of State Mandated Benefits, H-165.841, Comprehensive Health System Reform, H-165.838, Health System Reform Legislation, and H-160.922, Physician and Health Plan Provision of Uncompensated Care.
D-180.991	Work Plan for Maintaining Privacy of Physician Medical Information	The AMA shall recommend that medical staffs, managed care organizations and other credentialing and licensing bodies adopt credentialing processes that are compliant with the Americans with Disabilities Act and communicate this recommendation to all appropriate entities.	Rescind. This policy has been superseded by more recent and comprehensive policies including H-275.970, Licensure Confidentiality, and H-275.945, Self-Incriminating Questions on

			Applications for Licensure and Specialty Boards.
D-200.976	Transparency in Recruiting and Marketing Techniques for Young Physicians	Our AMA will: (1) explore strategies to increase transparency in marketing techniques used to recruit physicians who are finishing their residency or fellowship to ensure that hospitals, clinics, or health plans are not using deceptive or anti-competitive recruiting techniques without fully disclosing all components of any contract with the physician being recruited; and (2) work through its councils and sections to develop resources to assist physicians in training in career decision-making that provides them the full range of information concerning various practice models, including private practice.	Rescind. Since the directive was adopted 10 years ago, there have been numerous policies adopted, including H-225.950, AMA Principles for Physician Employment and D-383,978, Restrictive Covenants of Large Health Care Systems. Numerous resources have been developed to help physicians make informed career choices, including Practice Options for Physicians; Signing an Employment Contract; and Joining physician-led integrated systems: A guide to better decision making. Also, the sections, notably the RFS and YPS, often convene educational programs on these topics. Lastly, as part of its Professional Satisfaction and Practice Sustainability initiative, the AMA is developing tools physicians can use to enhance the practice of medicine and help them make informed decisions about their practice environments.
D-225.977	Physician Independence and Self-Governance	Our AMA will: (1) continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; and (2) promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care	Retain. While the directive has been foundational for the development of many AMA policies (H-225.950, AMA Principles for

		organizations, in order to assure and be accountable for the delivery of quality health care.	Physician Employment; D-215.990, AMA Assistance for Members in Matters Pertaining to Physician-Hospital/Health System Relationships; H-225.964, Hospital Employed/Contracted Physicians Reimbursement, and G-615.105, Employed Physicians and the AMA), retention will underscore the AMA's stance on employed physicians and provide another example of the AMA's support of employed physicians.
D-225.990	Medicare Payment for the Medical Direction and Supervision of Hospital-Based Clinical Laboratories	Our AMA urge the Department of Health and Human Service-Office of Inspector General to revise its Compliance Program Guidance for the Hospital Industry to state that token payment or non-payment for pathologist Part A medical direction and supervision services in exchange for Part B referrals violates the anti-kickback statute.	Rescind. OIG issued supplemental guidelines for hospitals and clinical laboratories that address Federal anti-kickback statutes, together with the safe harbor regulations and preambles, OIG fraud alerts and experience gained from investigations conducted by the OIG and the Department of Justice.
D-315.990	Physician Patient Privilege	Our AMA will: (1) periodically inform its members of their legal responsibilities relating to the confidentiality and release of privileged patient information under applicable federal law; and (2) develop model consent forms to be used by physicians.	Rescind. Superseded by more recent and/or comprehensive policies, including H-315.964, Confidentiality and Privacy Protections Ensuring Care Coordination and the Patient-Physician Relationship; H-

			320.944, Standardized Preauthorization Forms; D-315.992, Police, Payer and Government Access to Patient Health Information.
D-350.996	Strategies for Eliminating Minority Health Care Disparities	Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.	Rescind. This policy has been superseded by more recent and/or comprehensive policies, including H-180.944 Plan for Continued Progress Toward Health Equity | AMA (ama-assn.org) H-350.972 Improving the Health of Black and Minority Population | AMA (ama-assn.org) H-350.974 Racial and Ethnic Disparities in Health Care | AMA (ama-assn.org) D-350.995 Reducing Racial and Ethnic Disparities in Health Care | AMA (ama-assn.org) H-350.972, Improving the Health of Black and Minority Populations, H-350.971, AMA Initiatives Regarding Minorities, and D-350.995, Reducing Racial and Ethnic Disparities in Health Care. Also, in 2019, our AMA launched the AMA Center for Health Equity.
D-385.986	Payment For Sonography	Our AMA, in collaboration with other specialty societies, shall vigorously advocate with Medicare and other payers that all appropriately trained physicians regardless of specialty be reimbursed for performing diagnostic sonography with appropriate documentation (including sonographically directed biopsy, aspiration, etc.) in situations with defined clinical indications.	Rescind. The actions requested have been accomplished. There have been no recent complaints from specialties regarding lack of reimbursement for

			these services. CPT continues to instruct providers to select the name of the procedure or service that accurately identifies the procedure performed.
D-435.991	Bioterrorism - Protection from Liability	Our AMA shall continue to work with the Congress to protect physicians from liability arising from providing medical care in an organized governmental response to bioterrorism.	Retain. Still relevant.
D-615.981	AMA Support for Medical Students	Our AMA will: (1) study the attendance of students in regional and national meetings and the relationship of that attendance with continued participation in the future; and (2) consider the development of a program of travel grants to include considerations of individual need, chapter development and other incentives to encourage student participation in meetings.	Retain. Still relevant and necessary as the MSS continues to study regional meeting attendance as well as attendance at MSS Meetings. While MSS is considering travel scholarships as directed by D-200.975, Supporting Women and Underrepresenting Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties, the program is in the very early phases of implementation.
D-620.991	Federal Physician Attendance at Medical Meetings	Our AMA will continue to work with the federal government to ensure that federal physicians are able to continue to participate in professional meetings and serve in leadership positions in organized medicine.	Retain as editorially amended. Still relevant.
G-600.011	Function, Role and Procedures of the House of Delegates	The function and role of the House of Delegates includes setting policy on health, medical, professional, and governance matters, as well as the broad principles within which AMA's business activities are conducted. The Board of Trustees is vested with the responsibility for the AMA's business strategy and the conduct of AMA affairs. Our AMA adopts the *AMA House of Delegates Reference Manual: Procedures, Policies and Practices* as the official method of procedure in handling and conducting the business before the AMA House of Delegates.	Retain. Still relevant and necessary.
G-600.014	Guidelines for Admission of Constituent	1. Constituent associations are medical associations of states, commonwealths, districts, territories, or possessions of the United States. The Board of	Retain. Still relevant and necessary to specify a process to

	Associations to our AMA House of Delegates	Trustees will review applications from new constituent associations seeking representation and recommend a course of action to the House of Delegates. The following guidelines shall be utilized in evaluating constituent association applications for representation in our American Medical Association House of Delegates: a. The organization must not be in conflict with the Constitution and Bylaws of our AMA with regard to discrimination in membership; b. The organization must identify the type of organization that it is (e.g., not-for-profit corporation, LLC, unincorporated association, etc.), and submit evidence that it is in good standing as that type of entity in its geographical area; c. The leadership of the organization must have been specifically directed by its members to take action to seek representation in the AMA House of Delegates; d. The organization must be the predominant representational organization of physicians in a state, commonwealth, district, territory or possession of the United States; e. Physicians should comprise the majority of the voting membership of the organization; f. The organization must identify the number of members in each of the following categories: medical students, resident/fellow physicians, practicing physicians, inactive physicians (e.g., retired), non-physician members, and provide a roster of its members who are current in payment of dues and eligible to hold office; and g. The organization must be established and stable. 2. Only one constituent association from each state, commonwealth, district, territory or possession of the United States shall be recognized by the House of Delegates for purposes of representation in the House of Delegates; and 3. Each constituent association seeking representation in the House of Delegates must agree to abide by Policy G-620.030, "Statement of Collaborative Intent."	admit potential new constituent associations into our House of Delegates.
G-600.015	AMA Delegations	State and specialty medical societies are encouraged to adopt election procedures through which only AMA members may cast ballots for the state/specialty society's delegates to our AMA. Also, medical societies are encouraged to develop methods for selecting AMA delegates that provide an exclusive role for AMA members. It is also suggested that each delegation have at least one member involved in the governance of the sponsoring organization.	Retain but consolidate with G-600.030, Diversity of AMA Delegations into a single comprehensive policy addressing AMA Delegations. The principles outlined are still very much relevant.
G-600.019	Probationary Period for	The specialty organizations placed on one year probation are expected to work with AMA membership to develop a plan to increase their	Retain part of the policy. The first policy is still

	Specialty Societies	AMA membership and meet the responsibilities of National Medical Specialty Organizations as provided in Section 8.2 of the Bylaws. ~~Our AMA will work towards implementation of data licensing agreements with the specialty organizations seated in the House of Delegates that will provide them with the ability to view a portion of the AMA eprofile application for the sole purpose of AMA membership verification.~~	relevant; the second has been accomplished: some but not all specialties avail themselves of the developed process.
G-600.022	Admission of Professional Interest Medical Associations to our AMA House	(1) Professional Interest Medical Associations (PIMAs) are organizations that relate to physicians along dimensions that are primarily ethnic, cultural, demographic, minority, etc., and are neither state associations nor specialty societies. The following guidelines will be utilized in evaluating PIMA applications for representation in our AMA House of Delegates (new applications will be considered only at Annual Meetings of the House of Delegates): (a) the organization must not be in conflict with the Constitution and Bylaws of our AMA; (b) the organization must demonstrate that it represents and serves a professional interest of physicians that is relevant to our AMA's purpose and vision and that the organization has a multifaceted agenda (i.e., is not a single-issue association); (c) the organization must meet one of the following criteria: (i) the organization must demonstrate that it has 1,000 or more AMA members; or (ii) the organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of our AMA; or (iii) that the organization was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of our AMA; (d) the organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application; (e) physicians should comprise the majority of the voting membership of the organization; (f) 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; (g) the organization must be active within the profession, and hold at least one meeting of its members per year; (h) the organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states; (i) the organization must submit a resolution or other official statement to show that the request is	Retain. Still relevant and necessary to specify a process to admit professional interest medical associations into our House of Delegates.

		approved by the governing body of the organization; and (j) if international, the organization must have a US branch or chapter, and this chapter must meet the above guidelines. (2) The process by which PIMAs seek admission to the House of Delegates includes the following steps: (a) a PIMA will first apply for membership in the Specialty and Service Society (SSS); (b) using specific criteria, SSS will evaluate the application of the PIMA and, if the organization meets the criteria, will admit the organization into SSS; (c) after three years of participation in SSS, a PIMA may apply for representation in our AMA House of Delegates; (d) SSS will evaluate the application of the PIMA, determine if the association meets the criteria for representation in our AMA House of Delegates, and send its recommendation to our AMA Board of Trustees; (e) the Board of Trustees will recommend to the House how the application of the PIMA should be handled; (f) the House will determine whether or not to seat the PIMA; and (g) if the application of a PIMA for a seat in the House is rejected, the association can continue to participate in SSS as long as it continues to meet the criteria for participation in SSS.	
G-600.030	Diversity of AMA Delegations	Our AMA encourages: (1) state medical societies to collaborate more closely with state chapters of medical specialty societies, and to include representatives of these organizations in their AMA delegations whenever feasible; (2) state medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity; (3) specialty and state societies to develop training and/or mentorship programs for their student, resident and fellow and young physician section representatives, and current HOD delegates for their future activities and representation of the delegation; (4) specialty and state societies to include in their delegations physicians who meet the criteria for membership in the Young Physicians Section; and (5) delegates and alternates who may be entitled to a dues exemption, because of age and retirement status, to demonstrate their full commitment to our AMA through payment of dues.	Retain. Policy is still relevant but consolidate with G-600.015 into a single comprehensive policy addressing AMA Delegations.
G-600.060	Introducing Business to the AMA House	AMA policy on introducing business to our AMA House includes the following: 1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The	Retain. Still relevant.

		Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website. 2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement. 3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process. 4. At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution. 5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which he or she considers significant or when requested to do so by the organization, and the actions taken in response to such contacts. 6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates. 7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House. 8. Resolutions will be placed on the Reaffirmation Consent Calendar when they are identical or substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy	

		Database identification number. When practical, the Reaffirmation Consent Calendar should also include a listing of the actions that have been taken on the current AMA policies that are equivalent to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the submitted resolution which resets the sunset clock for ten years. 9. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is made available to the House.	
G-600.061	Guidelines for Drafting a Resolution or Report	Resolutions or reports with recommendations to the AMA House of Delegates shall meet the following guidelines: 1. When proposing new AMA policy or modification of existing policy, the resolution or report should meet the following criteria: (a) The proposed policy should be stated as a broad guiding principle that sets forth the general philosophy of the Association on specific issues of concern to the medical profession; (b) The proposed policy should be clearly identified at the end of the resolution or report; (c) Recommendations for new or modified policy should include existing policy related to the subject as an appendix provided by the sponsor and supplemented as necessary by AMA staff. If a modification of existing policy is being proposed, the resolution or report should set out the pertinent text of the existing policy, citing the policy number from the AMA policy database, and clearly identify the proposed modification. Modifications should be indicated by underlining proposed new text and lining through any proposed text deletions. If adoption of the new or modified policy would render obsolete or supersede one or more existing policies, those existing policies as set out in the AMA policy database should be identified and recommended for rescission. Reminders of this requirement should be sent to all organizations represented in the House prior to the resolution submission deadline; (d) A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of the proposed policy, program, or action shall be generated by AMA staff in consultation with the sponsor. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in each fiscal note. When the resolution or report is estimated to have a resource implication of $50,000	Retain. Still relevant.

		or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing). No resolution or report that proposes policies, programs, or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy. 2. When proposing to reaffirm existing policy, the resolution or report should contain a clear restatement of existing policy, citing the policy number from the AMA policy database. 3. When proposing to establish a directive, the resolution or report should include all elements required for establishing new policy as well as a clear statement of existing policy, citing the policy number from the AMA policy database, underlying the directive. 4. Reports responding to a referred resolution should include the resolves of that resolution in its original form or as last amended prior to the referral. Such reports should include a recommendation specific to the referred resolution. When a report is written in response to a directive, the report should sunset the directive calling for the report. 5. The House's action is limited to recommendations, conclusions, and policy statements at the end of report. While the supporting text of reports is filed and does not become policy, the House may correct factual errors in AMA reports, reword portions of a report that are objectionable, and rewrite portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible. The supporting texts of reports are filed. 6. All resolutions and reports should be written to include both "MD and DO," unless specifically applicable to one or the other. 7. Reports or resolutions should include, whenever possible or applicable, appropriate reference citations to facilitate independent review by delegates prior to policy development. 8. Each resolution resolve clause or report recommendation must be followed by a phrase, in parentheses, that indicates the nature and purpose of the resolve. These phrases are the following: (a) New HOD Policy; (b) Modify Current HOD Policy; (c) Consolidate Existing HOD Policy; (d) Modify Bylaws; (e) Rescind HOD Policy; (f) Reaffirm HOD Policy; or (g) Directive to Take Action. 9. Our AMA's Board of Trustees, AMA councils,	

		House of Delegates reference committees, and sponsors of resolutions will try, whenever possible, to make adjustments, additions, or elaborations of AMA policy positions by recommending modifications to existing AMA policy statements rather than creating new policy.	
G-600.064	AMA Endorsement of Screening Tests or Standards	(1) Delegates, state, or specialty societies submitting a resolution seeking endorsement or AMA adoption of specific screening tests must also submit an evidence-based review that determines the strength or quality of the evidence supporting their request, and that evaluates the degree to which the test satisfies the minimal criteria for validating the appropriateness of the screening test, which are: (a) the test must be able to detect the target condition earlier than without screening and with sufficient accuracy to avoid producing large numbers of false-positive and false-negative results; and (b) screening for and treating persons with early disease should improve the likelihood of favorable health outcomes compared with treating patients when they present with signs or symptoms of disease. (2) This review will be made available to the reference committee, which will either recommend to the House of Delegates that the resolution be referred or not be adopted.	Retain. Still relevant and necessary. Policy denotes procedures that are followed.
G-600.070	Legal Support for Decision-making by the AMA House	The following procedure for providing legal advice on issues before the House shall be followed: (1) All resolutions received by the AMA Office of House of Delegates Affairs also will be reviewed by the Office of the General Counsel. When a resolution poses serious legal problems, the Speaker, legal counsel, or other AMA staff will communicate with the sponsor or medical association; (2) If the text of the proposed resolution that poses serious legal problems is not changed or if the resolution is not withdrawn, the Chair or another member of the Board will be available to speak to the legal objections in open or executive sessions of the reference committee or before the House of Delegates; (3) In the case of late resolutions that pose serious legal problems, the Chair or another member of the Board will inform the House of Delegates of the legal objections prior to a vote to accept or reject the resolution; (4) In accordance with the current procedures, any reference committee may request the Office of the General Counsel to provide additional legal advice and other information during the committee's executive session; and (5) During HOD meetings, delegates may also seek legal advice regarding proposed resolutions and amendments on an individual basis from the Office of the General Counsel.	Retain. Still relevant and necessary. Policy denotes process for provision of legal advice.

G-600.100	AMA Programs for Delegates and Alternate Delegates	AMA policy on programs for Delegates and Alternate Delegates includes the following: (1) the Speaker of the House of Delegates shall solicit proposals from various AMA departments to hold programs for AMA Delegates; (2) these programs should be held at our AMA Meetings at times that minimize scheduling conflicts with House of Delegates or Reference Committee meetings, and (3) materials from such programs shall be made available to those who are unable to attend.	Retain. Still relevant and necessary. Policy denotes provision of educational programs.
G-600.110	Sunset Mechanism for AMA Policy	1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years. 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports. 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished. 4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the *AMA House of Delegates Reference Manual: Procedures, Policies and Practices*. 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.	Retain. Still relevant. Policy is consistent with process.

		6. Sunset policies will be retained in the AMA historical archives.	
G-600.111	Consolidation and Reconciliation of AMA Policy	Our AMA House of Delegates endorses the concept of consolidating its policies in order to make information on existing AMA policy more accessible and to increase the readability of our AMA Policy Database and our AMA PolicyFinder Program. (1) The policy consolidation process allows for: (a) rescinding outmoded and duplicative policies, and (b) combining policies that relate to the same topic. (2) Our AMA House requests that each AMA council, AMA section, and Board of Trustees advisory committee accept ongoing responsibility for developing recommendations on how to consolidate the policies in specific sections of our AMA Policy Database. In developing policy consolidation recommendations, our AMA councils should seek input from all relevant AMA bodies and units. Other groups represented in the House of Delegates also are encouraged to submit consolidation recommendations to the Speakers. (3) The House encourages each AMA council to develop two or more policy consolidation reports each year, recommending changes that will result in significant improvements in the readability of our AMA Policy Database. (4) The consolidation process permits editorial amendments for the sake of clarity, so long as the proposed changes are transparent to the House and do not change the meaning. (5) Policy Reconciliation. The AMA's policy database should not include duplicative, conflicting or inconsistent AMA policies. (A) If a new or modified policy supersedes or renders obsolete one or more existing AMA policies, those existing policies should be identified and presented to the AMA House of Delegates with a recommendation for rescission. The AMA Councils, with the input of appropriate AMA sections and Board advisory committees, have a role to play in reconciling existing policies by presenting reports with recommendations for policy reconciliation. Any organization that has representation in the AMA House of Delegates is encouraged to identify to the Speakers inconsistent or obsolete policies. The Speakers should then decide whether a policy reconciliation report is in order and which council or other entity should most appropriately be asked to develop the consolidation report. (B) At each meeting, the Speaker will 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	Retain. Still relevant. Policy is consistent with process.

		obsolete. Where a report is needed to reconcile disparate policies, the Speakers will identify the appropriate council or group responsible for the reconciliation report on a specific topic.	
G-600.125	AMA Meeting Schedule	1. (A) Our AMA will convene as a pilot a combined interim policy making meeting and National Advocacy Conference; (B) the combined meetings will be held at a location in the Washington, DC metropolitan area and at an appropriate time to avoid incurring contractual penalties; (C) the pilot will take place within a reasonable time frame, and with adequate notice to members of the House of Delegates; and (D) our AMA sections will be afforded the opportunity to meet immediately prior to and in close proximity to the meetings of the House of Delegates. 2. Our AMA will organize and implement the pilot as specified in # 1 above. 3. A study and report on the feasibility and logistics of reorganized future meeting dates and schedules shall be developed and presented to the House of Delegates. 4. State and specialty societies shall be queried on the potential number of members who would attend a new, revised interim/NAC meeting.	Rescind. Policy is contrary to current Policy G-600.130, Meeting Calendar and Locations.
G-605.010	Board Planning	The Board develops its own annual plan to guide its agenda-setting process to include the following key elements: (1) The agenda should span multiple meetings to ensure that the various phases of planning, implementation, and mid-course correction receive appropriate attention for those initiatives considered vital to the Board's strategic priorities. (2) The Board should actively seek input from AMA internal stakeholders, such as other medical organizations considered part of the federation of medicine, in defining the Board's longer-range agenda. (3) The Board should develop its own annual work plan during its yearly planning retreat and should consider revisions to that plan during each subsequent Board meeting. (4) All Board members should have the opportunity to participate in the agenda-setting process. (5) The material supplied to the Board during meetings must explicitly show how these matters relate to the strategic imperatives of our AMA. (6) Each standing committee of the Board should develop its annual plan with progress presentations as standard items for the Board agenda/meetings. (7) Input from members of the HOD, including views about top priority issues, will be solicited by the Board in support of the strategic planning process, along with other sources of input such as surveys of members and CLRPD's stakeholder analysis.	Rescind. The Board has a comprehensive strategic planning process utilizing input from the HOD, the Federation, Councils, Sections, and individual Board members.

G-605.035	Endorsements for Public Office	Our AMA requires that all of its endorsements of nominations of appointed officials for public office be considered and voted upon by our Board of Trustees prior to any public pronouncements of support.	Retain. Still relevant and necessary. Policy denotes current procedure.
G-605.050	Annual Reporting Responsibilities of the AMA Board of Trustees	The AMA Board provides the following four items to the AMA House: (1) At each Annual Meeting of the House, the Board submits a report to the House that provides highlights on the AMA's performance, activities, and status in the previous calendar year as well as a recommendation for the Association's dues levels for the next year. The report should include information on topics such as: (a) AMA's performance relative to its strategic plan; (b) key indicators of the AMA's financial performance and, if not provided through other communication vehicles, information on the compensation of Board members, elected Officers, the Executive Vice President, and the expenses associated with the AMA Councils, Sections, Special Groups, and AMA's participation in the World Medical Association; (c) an assessment of the performance, accomplishments, and activities of the Board, including the AMA appearance program and the results of the work of the Board's Audit Committee; (d) AMA's membership situation, including an assessment of the membership communication and promotion activities; (e) highlights of the activities and accomplishments of the Association's major programs, including legislative and private sector advocacy; (f) a description and assessment of efforts to address high priority issues; and (g) the AMA's relationships and work with other organizations, including Federation organizations, other health related organizations, non-health related organizations, and international organizations. The Board may include any other topics in this report that it deems important to communicate to the House about the performance, activities, and status of the AMA and the health of the public. (2) As the principal planning agent for the AMA, the Board provides a report at each Interim Meeting of the House that recommends the AMA's strategic directions and plan for the next year and beyond. The report should include a discussion of the AMA's membership strategy. (3) At each Interim Meeting, the Board provides an informational report on the AMA's legislative and regulatory activities, including the Association's accomplishments in the previous 12 months and a forecast of the legislative and regulatory issues that are likely to occupy the Council on Legislation and other components of the AMA's for the next year. In fulfilling its responsibilities to report to the	Retain. Still relevant and necessary. Policy denotes annual reports submitted by the BOT.

		House on topics and situations, the Board should provide succinct reports to the House. When detailed information on topics is warranted, the Board should provide the information to interested members of the House through reports that can be downloaded from the AMA web site. Nothing in this policy precludes the House from requesting that the Board report back to the House on any topic. Further, nothing in this policy should be construed as limiting the number or size of reports that the Board can send to the House.	
G-605.051	Situational Reporting Responsibilities of the AMA Board of Trustees	The Board of Trustees provides reports to the House when the following situations occur: (1) the Board submits a report to the House when the Board takes actions that differ from current AMA policy; (2) consistent with AMA Bylaws, the Board submits a report to the House when the Board determines that the expenditures associated with recommendations and resolves that were adopted by the House would be inadvisable; (3) consistent with AMA Bylaws, the Board transmits reports of the SSS to the House and informs the House of important developments with regard to Federation organizations; and (4) consistent with Policy G-630.040, the Board reports to the House when the Board's review of the AMA's Principles on Corporate Relationships results in recommendations for changes in the Principles. In fulfilling its responsibilities to report to the House when certain specified situations develop, the Board should provide succinct reports to the House and, if additional detail is needed, use the AMA web site to provide the additional information to interested members of the House.	Retain. Still relevant and necessary. Policy denotes current reporting responsibilities of the BOT.
G-610.060	Nomination of International Medical Graduates to Medical Education Leadership Positions	~~Our AMA will (1) encourage the candidacy of well qualified International Medical Graduates for the Council on Medical Education; and (2) strongly consider well qualified IMGs for nomination to the Accreditation Council for Graduate Medical Education Board of Directors.~~ ~~(CME Rep. 5, A-05; CCB/CLRPD Rep. 3, A-12)~~ H-255.988(14), "AMA Principles on International Medical Graduates," through edits as shown below: The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review	Retain. Still relevant but consolidate into a single comprehensive policy H-255.988, AMA Principles on International Medical Graduates, as indicated.

		committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.	
G-615.030	Council Activities	~~Our AMA will (1) encourage the candidacy of well qualified International Medical Graduates for the Council on Medical Education; and (2) strongly consider well qualified IMGs for nomination to the Accreditation Council for Graduate Medical Education Board of Directors.~~ ~~(BOT Rep. 15, A-00; Consolidated: CLRPD Rep. 3, I-01; Rep. of the Speakers Special Advisory Committee on the House of Delegates, A-09; Modified: CCB/CLRPD Rep. 3, A-12)~~ H-255.988(14), "AMA Principles on International Medical Graduates," through edits as shown below: The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.	Retain. Still relevant but consolidate into a single comprehensive policy H-255.988, AMA Principles on International Medical Graduates, as indicated.
G-615.071	Activities of the Council on Legislation	1. Our AMA Council on Legislation (COL) will continue to convene forums at AMA meetings to provide members of the Federation an opportunity to hear about and discuss major and emerging legislative and regulatory issues important to physicians and patients. 2. The COL will be represented at AMA-convened meetings focused on advocacy, such as the State Advocacy Summit ~~Legislative Strategy Conference~~ and National Advocacy Conference. 3. COL members will actively represent, at the discretion of the Chair of the Board of Trustees, our AMA before state and federal government committees and agencies.	Retain as editorially amended for accuracy. Still relevant.
G-615.100	Organized Medical Staff Section (OMSS)	AMA policy on the Organized Medical Staff Section (OMSS) includes the following: (1) Our AMA encourages all U.S. hospitals to support representation of their medical staffs in our AMA Organized Medical Staff Section meetings; and (2) Our AMA will continue to (a) communicate to the chiefs of staff of hospitals and executive directors of organized medical groups the	Retain. Still relevant and necessary. The policy provides clear guidance on the function of the Section. The OMSS continues to be the group dedicated to

		significance of medical staff participation in organized medicine; and (b) encourage them to appoint a representative (by election or selection, according to their by-laws) to attend the AMA-OMSS meetings and then communicate information back to members of their medical staff.	supporting organized medical staffs.
G-620.019	Organizations Inaccurately Claiming to Represent Physicians	Our AMA will (1) challenge any organization that falsely claims to represent physicians and (2) formulate an appropriate response to inaccuracies that other organizations portray about the representation of physicians.	Retain. Still relevant. Policy denotes current AMA process.
G-620.021	Communications and Collaboration with the Federation	Our AMA: (1) when confronted with attempts by non-physicians to expand scope of practice via state legislation, shall work at the invitation of its component societies to develop strategies to most effectively promote and protect the best interest of our patients; (2) shall continue to work with national medical specialty societies to assist them in working with and coordinating activities with state medical associations and that the AMA, when requested by either a state medical association or a national specialty society, provide a mechanism to attempt to resolve any dispute between such organizations; (3) shall become actively involved in lobbying and/or communicating with state officials at the request of the state medical associations. (4) Prior to placing targeted advertising, our AMA will contact the relevant state medical associations and/or specialty societies for the purpose of enhancing communication about AMA's planned activities.	Retain. Still relevant. Policy denotes current communication/collaboration focus and process.
G-620.030	Statement of Collaborative Intent	AMA policy on the activities of its Councils includes the following: (1) The Councils should actively seek stakeholder input into all items of business; (2) Individual AMA Councils are allowed to prioritize tasks assigned to their respective work subject areas taking into consideration established AMA strategic priorities and the external regulatory, business, and legislative environment affecting our AMA membership and the health care system in which we provide care to our patients; and (3) Online tools and the AMA web site will be used to provide ways for members of the HOD, other AMA parties (eg, councils, sections, etc.), AMA members, and other invited parties, to provide comments on the activities and work of the AMA councils on a timely basis, and that councils make draft reports available online for comment when time and circumstances permit.	Retain. Still relevant and necessary. Policy denotes current procedure.
G-620.032	AMA Dispute Resolution Activities	Requests to the AMA for assistance in inter-specialty dispute resolution shall be considered on a case-by-case basis.	Retain. Still relevant.

G-620.042	Enhancing the Functionality of the Federation	The Federation of Medicine includes the AMA, organizations with voting representation in the AMA House of Delegates and their component societies that voluntarily relate to each other in an implied set of working relationships and understandings. (1) A pre-determined level of funding should be established (scaled accordingly to the size of the organization) for any AMA/Federation work groups. (a) Funds requested and received from state, county, and specialty organizations should be placed in a separate bank account; and (b) Our AMA should contribute a pre-determined amount and increase the amount according to the needs of the projects. (2) The governing body of each member of the Federation should endorse the Statement of Collaborative Intent as an important first step toward strengthening the Federation. (3) The needs and demands of physicians and their practices must be the prime objective of organized medicine as it seeks to improve the value of membership for its constituents. (4) Because the governance and function of medical societies are intertwined, the study of each aspect should not occur separately. Members of the Federation must take the Federation-wide perspective and not focus narrowly on their own individual organizations. Components of the Federation should trust and be more willing to collaborate and coordinate with other organizations for the good of the Federation and all physicians in the country. (5) Membership organizations must increasingly work together and share costs for projects and activities that enhance physicians' and patients' needs. (6) For the Federation of Medicine to be effective, all elements of the Federation which have an interest in any given issue must be included in organized activities. The form of the entity developed to address an issue must also be flexible to allow participation by all interested parties. Participation may be at the local, state, or national level, depending on the issue. (7) A collaborative mechanism must be developed that in times of crisis allows Federation component societies to coordinate and focus all available resources to resolve such issues on behalf of physicians. (8) The Federation should encourage interaction between component organizations at the county, state, and national levels, and provide an organizational structure that brings similar types of societies together in working groups to act on issues of importance. (9) A rapid-response mechanism should be developed to bring items of vital interest to the attention of the designated leaders from each Federation component with expectations of timely response. (10) The components of the Federation should indicate which person or persons within each	Rescind. The Statement of Collaborative Intent was drafted in 1996 (BOT Report 2-A-96) to guide the Federation Coordination Team, and the intent of the resulting policy has been realized.

		organization qualifies as the key leader who can speak for the organization and develop a response mechanism for providing timely input to facilitate decision-making at the Federation level. (11) The Federation must strengthen the effectiveness of each organization's governing body to enhance the inter-workings of the Federation. (12) The Federation should acknowledge and encourage mergers of like societies to allow them a stronger voice in our AMA House of Delegates for their members.	
G-620.050	Greater Involvement of Medical Students in Federation Organizations	Our AMA encourages medical societies to provide mechanisms for more direct involvement of students at the state and local levels, and to implement membership options for their state's medical students who are enrolled in medical school for longer than four years. Our AMA will work with the Association of American Medical Colleges to promote medical student engagement in professional medical societies, including attendance at local, state, and national professional organization meetings, during the pre-clinical and clinical years.	Retain. Still relevant.
G-625.011	AMA Goals, Roles and Obligations	Our AMA: (1) reaffirms its goal to be the unified voice of the medical profession speaking for all physicians, and (2) above all, affirms its role and obligations as a steward of our professional values, as well as the right and obligation of individual physicians to participate in the process.	Retain. Still relevant.
G-625.012	Betterment of Public Health	Our AMA reaffirms that the betterment of the public's health is our highest goal, and that our efforts in our House of Delegates, Board of Trustees, external advocacy, and around the world reflect that value.	Retain. Still relevant.
G-630.015	Selecting an EVP	(1) The Search Committee for the AMA Executive Vice President should have equal representation from the Board of Trustees and House of Delegates, with the Board members of the Committee appointed by the Chair of the Board and the House of Delegates Members appointed by the Speaker, with the Chair of the Committee appointed by the Chair of the Board of Trustees. (2) Outside legal counsel shall be retained on behalf of AMA to negotiate and draft the employment contract for the Executive Vice President.	Retain but consolidate with G-630.010, Executive Vice President, which outlines the qualifications, roles and responsibilities of the AMA Executive Vice President.
G-630.025	Outside Legal Counsel	1) The General Counsel shall coordinate the retention of all outside legal counsel on behalf of AMA, unless the legal matter directly concerns the employment or performance of the General Counsel. 2) The Office of General Counsel shall develop criteria for consulting with outside counsel.	Retain. Still relevant
G-630.040	Principles on Corporate Relationships	The House of Delegates adopts the following revised principles on Corporate Relationships. The Board will review them annually and, if necessary, make recommendations for revisions to be	Retain. Remains relevant to the business and

		presented to the House of Delegates. (1) GUIDELINES FOR AMA CORPORATE RELATIONSHIPS. Principles to guide AMA's relationships with corporate America were adopted by our AMA House of Delegates at its December 1997 meeting and slightly modified at the June 1998 meeting. Subsequently, they have been edited to reflect the recommendations from the Task Force on Association/Corporate Relations, including among its members experts external to our AMA. Minor edits were also adopted in 2002. The following principles are based on the premise that in certain circumstances, our AMA should participate in corporate arrangements when guidelines are met, which can further our AMA's core strategic focus, retain AMA's independence, avoid conflicts of interest, and guard our professional values. (2) OVERVIEW OF PRINCIPLES. The AMA's principles to guide corporate relationships have been organized into the following categories: General Principles that apply to most situations; Special Guidelines that deal with specific issues and concerns; Organizational Review that outlines the roles and responsibilities of the Board of Trustees, AMA Management and other staff units. These guidelines should be reviewed over time to assure their continued relevance to the policies and operations of our AMA and to our business environment. The principles should serve as a starting point for anyone reviewing or developing AMA's relationships with outside groups. (3) GENERAL PRINCIPLES. Our AMA's vision and values statement and strategic focus should provide guidance for externally funded relationships. Relations that are not motivated by the association's mission threaten our AMA's ability to provide representation and leadership for the profession. (a) Our AMA's vision and values and strategic focus ultimately must determine whether a proposed relationship is appropriate for our AMA. Our AMA should not have relationships with organizations or industries whose principles, policies or actions obviously conflict with our AMA's vision and values. For example, relationships with producers of products that harm the public health (e.g., tobacco) are not appropriate for our AMA. Our AMA will proactively choose its priorities for external relationships and collaborate in those that fulfill these priorities. (b) The relationship must preserve or promote trust in our AMA and the medical profession. To be effective, medical professionalism requires the public's trust. Corporate relationships that could undermine the public's trust in our AMA or the profession are not acceptable. For example, no	functioning of the AMA

		relationship should raise questions about the scientific content of our AMA's health information publications, AMA's advocacy on public health issues, or the truthfulness of its public statements. (c) The relationship must maintain our AMA's objectivity with respect to health issues. Our AMA accepts funds or royalties from external organizations only if acceptance does not pose a conflict of interest and in no way impacts the hobjectivity of the association, its members, activities, programs, or employees. For example, exclusive relationships with manufacturers of health-related products marketed to the public could impair our AMA's objectivity in promoting the health of America. Our AMA's objectivity with respect to health issues should not be biased by external relationships. (d) The activity must provide benefit to the public's health, patients' care, or physicians' practice. Public education campaigns and programs for AMA or Federation members are potentially of significant benefit. Corporate-supported programs that provide financial benefits to our AMA but no significant benefit to the public or direct professional benefits to AMA or Federation members are not acceptable. In the case of member benefits, external relations must not detract from AMA's professionalism. (4) SPECIAL GUIDELINES. The following guidelines address a number of special situations where our AMA cannot utilize external funding. There are specific guidelines already in place regarding advertising in publications. (a) Our AMA will provide health and medical information, but should not involve itself in the production, sale, or marketing to consumers of products that claim a health benefit. Marketing health-related products (e.g., pharmaceuticals, home health care products) undermines our AMA's objectivity and diminishes its role in representing healthcare values and educating the public about their health and healthcare. (b) Activities should be funded from multiple sources whenever possible. Activities funded from a single external source are at greater risk for inappropriate influence from the supporter or the perception of it, which may be equally damaging. For example, funding for a patient education brochure should be done with multiple sponsors if possible. For the purposes of this guideline, funding from several companies, but each from a different and non-competing industry category (e.g., one pharmaceutical manufacturer and one health insurance provider), does not constitute multiple-source funding. Our AMA recognizes that for some activities the benefits may be so great, the harms so minimal, and the prospects for developing multiple	

		sources of funding so unlikely that single-source funding is a reasonable option. Even so, funding exclusivity must be limited to program only (e.g., asthma conference) and shall not extend to a therapeutic category (e.g., asthma). The Board should review single-sponsored activities prior to implementation to ensure that: (i) reasonable attempts have been made to locate additional sources of funds (for example, issuing an open request for proposals to companies in the category); and (ii) the expected benefits of the project merit the additional risk to our AMA of accepting single-source funding. In all cases of single-source funding, our AMA will guard against conflict of interest. (c) The relationship must preserve AMA's control over any projects and products bearing our AMA name or logo. Our AMA retains editorial control over any information produced as part of a corporate/externally funded arrangement. When an AMA program receives external financial support, our AMA must remain in control of its name, logo, and AMA content, and must approve all marketing materials to ensure that the message is congruent with our AMA's vision and values. A statement regarding AMA editorial control as well as the name(s) of the program's supporter(s) must appear in all public materials describing the program and in all educational materials produced by the program. (This principle is intended to apply only to those situations where an outside entity requests our AMA to put its name on products produced by the outside entity, and not to those situations where our AMA only licenses its own products for use in conjunction with another entity's products.) (d) Relationships must not permit or encourage influence by the corporate partner on our AMA. An AMA corporate relationship must not permit influence by the corporate partner on AMA policies, priorities, and actions. For example, agreements stipulating access by corporate partners to the House of Delegates or access to AMA leadership would be of concern. Additionally, relationships that appear to be acceptable when viewed alone may become unacceptable when viewed in light of other existing or proposed activities. (e) Participation in a sponsorship program does not imply AMA's endorsement of an entity or its policies. Participation in sponsorship of an AMA program does not imply AMA approval of that corporation's general policies, nor does it imply that our AMA will exert any influence to advance the corporation's interests outside the substance of the arrangement itself. Our AMA's name and logo should not be used in a manner that would express or imply an AMA endorsement of the corporation,	

		its policies and/or its products. (f) To remove any appearance of undue influence on the affairs of our AMA, our AMA should not depend on funding from corporate relationships for core governance activities. Funding core governance activities from corporate sponsors, i.e., the financial support for conduct of the House of Delegates, the Board of Trustees and Council meetings could make our AMA become dependent on external funding for its existence or could allow a supporter, or group of supporters, to have undue influence on the affairs of our AMA. (g) Funds from corporate relationships must not be used to support political advocacy activities. A full and effective separation should exist, as it currently does, between political activities and corporate funding. Our AMA should not advocate for a particular issue because it has received funding from an interested corporation. Public concern would be heightened if it appeared that our AMA's advocacy agenda was influenced by corporate funding. (5) ORGANIZATIONAL REVIEW. Every proposal for an AMA corporate relationship must be thoroughly screened prior to staff implementation. AMA activities that meet certain criteria requiring further review are forwarded to a committee of the Board of Trustees for a heightened level of scrutiny. (a) As part of its annual report on the AMA's performance, activities, and status, the Board of Trustees will present a summary of the AMA's corporate arrangements to the House of Delegates at each Annual Meeting. (b) Every new AMA Corporate relationship must be approved by the Board of Trustees, or through a procedure adopted by the Board. Specific procedures and policies regarding Board review are as follows: (i) The Board routinely should be informed of all AMA corporate relationships; (ii) Upon request of two dissenting members of the CRT, any dissenting votes within the CRT, and instances when the CRT and the Board committee differ in the disposition of a proposal, are brought to the attention of the full Board; (iii) All externally supported corporate activities directed to the public should receive Board review and approval; (iv) All activities that have support from only one corporation except patient materials linked to CME, within an industry should either be in compliance with ACCME guidelines or receive Board review; and (f) All relationships where our AMA takes on a risk of substantial financial penalties for cancellation should receive Board review prior to enactment. (c) The Executive Vice President is responsible for	

		the review and implementation of each specific arrangement according to the previously described principles. The Executive Vice President is responsible for obtaining the Board of Trustees authorization for externally funded arrangements that have an economic and/or policy impact on our AMA. (d) The Corporate Review Team reviews corporate arrangements to ensure consistency with the principles and guidelines. (i) The Corporate Review Team is the internal, cross-organizational group that is charged with the review of all activities that associate the AMA's name and logo with that of another entity and/or with external funding. (ii) The Review process is structured to specifically address issues pertaining to AMA's policy, ethics, business practices, corporate identity, reputation, and due diligence. Written procedures formalize the committee's process for review of corporate arrangements. (iii) All activities placed on the Corporate Review Team agenda have had the senior manager's review and consent and following CRT approval will continue to require the routine approvals of the Office of Finance and Office of the General Counsel. (iv) The Corporate Review Team reports its findings and recommendations directly to a committee of the Board. (e) Our AMA's Office of Risk Management in consultation with the Office of the General Counsel will review and approve all marketing materials that are prepared by others for use in the U.S. and that bear our AMA's name and/or corporate identity. All marketing materials will be reviewed for appropriate use of AMA's logos and trademarks, perception of implied endorsement of the external entity's policies or products, unsubstantiated claims, misleading, exaggerated or false claims, and reference to appropriate documentation when claims are made. In the instance of international publishing of JAMA and the Archives, our AMA will require review and approval of representative marketing materials by the editor of each international edition in compliance with these principles and guidelines. (6) ORGANIZATIONAL CULTURE AND ITS INFLUENCE ON EXTERNALLY FUNDED PROGRAMS. (a) Organizational culture has a profound impact on whether and how AMA corporate relationships are pursued. AMA activities reflect on all physicians. Moreover, all physicians are represented to some extent by AMA actions. Thus, our AMA must act as the professional representative for all physicians, and not merely as an advocacy group or club for AMA members. (b) As a professional organization, our AMA operates with a higher level of purpose representing	

		the ideals of medicine. Nevertheless, non-profit associations today do require the generation of non-dues revenues. Our AMA should set goals that do not create an undue expectation to raise increasing amounts of money. Such financial pressures can provide an incentive to evade, minimize, or overlook guidelines for fundraising through external sources. (c) Every staff member in the association must be accountable to explicit ethical standards that are derived from the vision, values, and focus areas of the Association. In turn, leaders of our AMA must recognize the critical role the organization plays as the sole nationally representative professional association for medicine in America. AMA leaders must make programmatic choices that reflect a commitment to professional values and the core organizational purpose.	
G-630.090	AMA Publications	AMA policy on its publications includes the following: (1) JAMA and other AMA scientific journals should display a disclaimer in prominent print that the editorial views are not necessarily AMA policy. (2) Our AMA, in all of its publications and correspondence, will use the correct title for the medical specialist. (3) Our AMA recommends that medical journal articles using acronyms should have a small glossary of acronyms and phrases displayed prominently in the article. (4) The House of Delegates affirms that JAMA and The JAMA Network journals shall continue to have full editorial independence as set forth in the AMA Editorial Governance Plan.	Retain. Still relevant.
G-630.100	Conservation, Recycling and Other 'Green' Initiatives	AMA policy on conservation and recycling include the following: (1) Our AMA directs its offices to implement conservation-minded practices whenever feasible and to continue to participate in "green" initiatives. (2) It is the policy of our AMA to use recycled paper whenever reasonable for its in-house printed matter and publications, including JAMA, and materials used by the House of Delegates, and that AMA printed material using recycled paper should be labeled as such. (3) During meetings of the American Medical Association House of Delegates, our AMA Sections, and all other AMA meetings, recycling bins, where and when feasible, for white (and where possible colored) paper will be made prominently available to participants.	Retain. Still relevant.
G-630.121	The National Health Museum	Our AMA formally endorses the National Health Museum project.	Rescind. The effort to create a physical National Health Museum appears to be defunct.

G-630.155	AMA Government Relations Advocacy Fellowship	Our AMA will maintain a yearlong medical student Government Relations Advocacy Fellowship, with appropriate stipend, based in the Washington, DC office. The program's primary goal is to enhance advocacy for AMA priorities and engage the younger AMA members.	Retain. Still relevant.
G-630.160	National Advocacy Conference	The National Advocacy Conference will remain separate from the Interim Meeting. Unless special circumstances arise, our American Medical Association National Advocacy Conference shall be scheduled annually in the nation's capital, Washington, DC, in order to maximize the continuity and impact of the voice of medicine in visits with the members of the United States Congress.	Retain. Still relevant.
G-635.005	Membership and Governance	The House affirms that the AMA shall remain an association of voluntary, individual medical student and physician members and that the Association shall continue to be individually funded and organizationally governed through representation in the HOD.	Retain. Still relevant.
G-635.011	Participation of Individual Members in our AMA	Our AMA supports individual member, two-way electronic communications that promote active grassroots discussion of timely issues; regular feedback for AMA leadership; and a needed voice for diverse ideas and initiatives from throughout the Federation. AMA members are encouraged to participate in the activities of the AMA, particularly in the following ways: (1) Though the AMA website or other communications conduits, provide comments and suggestions to the AMA Board and the AMA Councils? on their policy development projects and on other AMA products and services; (2) Participate in the on-line discussion groups on the items of business included in the Handbook of the House of Delegates; (3) Communicate their views on the items of business in the House's Handbook to their AMA delegates and alternate delegates; (4) Inform the AMA, directly or through their AMA delegates, of situations that may represent opportunities to implement the Association's policy positions; (5) Help the AMA promote its policy positions; (6) When opportunities present themselves, explain the value of the AMA and the importance of belonging to the AMA to physicians; and (7) Work to help the AMA increase its membership level.	Retain. Still relevant and important.
G-635.053	AMA Membership Strategy: Osteopathic Medicine	Our AMA's membership strategy on osteopathic physicians (DOs) includes the following: Our AMA: (1) encourages all state societies to accept DOs as members at every level of the Federation; (2) encourages state societies with schools of osteopathic medicine to support development of Medical Student Sections at those schools; Both the MSS Governing Council and existing MSS chapters	Rescind. Policy has been implemented and is now standard practice.

		in states with osteopathic schools should assist in this effort; (3) encourages that DO members of our AMA continue to participate in the Membership Outreach program; (4) will provide recruiters with targeted lists of DO nonmembers upon request; (5) will include DOs, as appropriate, in direct nonmember mailings; and (6) will expand its database of information on osteopathic students and doctors.	
G-635.120	Dues Strategy	AMA's dues strategies include the following: (1) It is the constitutional duty of our AMA House of Delegates to set the membership dues structure. (a) Any reduction of the level of dues within each category of membership can only be done with the approval of the House of Delegates; and (b) Our AMA Board of Trustees will actively seek to obtain the cooperation of the state and component medical societies before and during any negotiations on reductions in the level of dues for groups. (2) Relying upon survey and other relevant data, our AMA Board of Trustees shall determine the dues and benefits of the International membership category. (3) Any Federation component choosing to continue to bill and collect AMA dues shall have signed a binding primary partnership agreement with our AMA. A binding primary partnership agreement for AMA membership billing and dues collection shall include the following elements: (i) utilization of our AMA standard membership application; (ii) acceptance of credit card payments for AMA dues; and (iii) agreed-upon performance standards and incentives. (4) Our AMA encourages state and local medical societies, and our AMA, to explore new programs, activities and services which can provide meaningful benefits to members, produce additional non-dues income for medical societies, make it possible to hold the line on dues, and provide potentials for increasing physician membership. (5) Our AMA commends those medical societies which are endeavoring to hold the line on dues as a responsive action to the needs of their members. (6) Our AMA and its constituent state and county medical societies should implement a policy whereby, upon written request from a member or appropriate staff member of a medical society, there would be a transfer of prepaid dues to the receiving county or state medical society upon receipt and acceptance of an application for membership transfer, so long as the dues were paid and transfer application received before the calendar/dues year began, or within 31 days thereafter. (7) Our AMA urges all county and state societies to review their dues structure for medical students so that the total dues for county, state, and AMA	Rescind. Policy has been implemented.

		membership can be held to a realistic figure. (8) Our AMA should develop and implement a dues program specifically designed to bridge the gap caused by the transition from residency into the first years of practice. It should implement multi-year dues options that span the transition periods from student to resident and/or resident to young physician and provide periodic benefits at specific points during the multi-year membership. (9) Our AMA membership dues delinquency date is March 1. Direct membership solicitation of dues-delinquent members is appropriate according to the individual Partnership for Growth agreements with state medical societies. (10) Our AMA will make a major organizational effort to persuade physicians' employers to allocate funds for professional development and Federation dues. (11) The House of Delegates approves the Partnership for Growth's Direct Program marketing entry date of February 1.	
G-635.140	Help with State Society Membership Recruiting	Our American Medical Association will: (1) continue to focus its efforts on increasing AMA membership in all states and all specialties by improving the AMA membership value proposition; (2) continue to engage in joint marketing activities with state or specialty medical societies when both the AMA and the state or specialty deem it to be mutually beneficial; and (3) continue to work to improve the medical practice environment for physicians.	Rescind. Policy has been implemented.
G-640.050	Preserving the AMA's Grassroots Legislative and Political Mission	Our AMA will ensure that all Washington activities, including lobbying, political education, grassroots communications, and membership activities be staffed and funded so that all reasonable legislative missions and requests by AMA members and constituent organizations for political action and training can be met in a timely and effective manner.	Retain. Still necessary to ensure that AMA advocacy continues to be funded at levels appropriate for lobbying efforts at the federal and state levels.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(A-22)

Introduced by: New York

Subject: Development of Resources on End of Life Care

Referred to: Reference Committee F

Whereas, The questions regarding life and death have been debated by scholars, philosophers, religious leaders and doctors for centuries and technology has blurred the distinction between a quality human life and biological life on a cellular or organ basis; and

Whereas, Economic, social and religious views influence modern definitions of human and biological life, making technology in modern medicine a double-edged sword, favoring the betterment of patients and their quality of life and care; and

Whereas, Physicians have been sworn to do no harm, yet this is increasingly challenging with today's competing forces of technology, shifting social morae's and the economics and legislation of health care; and

Whereas, Confronted/ burdened with the more complicated questions of when life begins and ends, physicians have not always been able to transition patients effectively from life to death, which has contributed to decreased use of tools such as palliative care and hospice care; and

Whereas, End-of-life care as defined by the World Health Organization (WHO) "is the term used to describe the support and medical care given during the time surrounding death"; and

Whereas, Palliative Care is the treatment of patients with serious illnesses and disease with the goal to help the patient feel better, prevent or alleviate symptoms and side effects of disease and treatment, treating the whole patient including the emotional, social, practical, and spiritual costs of that illnesses, striving to improve a patient's quality of life as they deal with serious illness; and

Whereas, Hospice is the treatment of patients at the end of life or with a terminal illness, generally for patients who have less than six months to live and which uses many elements of palliative care to keep patients comfortable during their transition from life to death; and

Whereas, Physicians need to educate themselves on what the treatment goals offer and the reasonableness of the outcome, while all physicians should understand what palliative and hospice care offer a patient in terms of treatment, palliative care is an appropriate bridge to care; and

Whereas, There needs to be more certificate programs for physicians on palliative care until such time as there are enough fellowship trained end of life physicians, education is critical with respect to hospice care which does not mean "no care" but should redefine the scope of care; and

Whereas, Currently, the delivery of end of life care is fragmented with services provided in the hospital, skilled nursing facility or community with each setting having different resources, definitions and protocols and no seamless way to transfer patients from one setting to the next and back again; and

Whereas, The current “one size fits all” approach does little to address the spectrum of end of life issues but reinforces the need for a centralized depository of end of life orders that is easily accessible; therefore be it

RESOLVED, That our American Medical Association develop educational resources for physicians, allied health professionals and patients on end of life care (Directive to Take Action); and be it further

RESOLVED, That our AMA work with all stakeholders to develop proper quality metrics to evaluate and improve palliative and hospice care. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(A-22)

Introduced by: New York

Subject: Report on the Preservation of Independent Medical Practice

Referred to: Reference Committee F

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1 Whereas, The number of physicians in independent practice of medicine has been rapidly
2 dwindling; and
3
4 Whereas, AMA policy is to advocate for the preservation of independent medical practice; and
5
6 Whereas, Many physicians are not members of the AMA, possibly because they are not
7 satisfied with or are unaware of the activities of the AMA to help physicians stay in private
8 practice; therefore be it
9
10 RESOLVED, That our American Medical Association issue a report every two years
11 communicating their efforts to support independent medical practices. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(A-22)

Introduced by: New York

Subject: September 11th as a National Holiday

Referred to: Reference Committee F

Whereas, September 11, 2001 took over 3,000 lives in an act of terrorism against the United States of America; and

Whereas, September 11, 2021 marked the twentieth anniversary of that horrific day; and

Whereas, Thousands of responders, uniformed and civilian, employed and volunteers, served at Ground Zero, the Pentagon and Shanksville, PA, risking their lives, being exposed to debris, powdered cement, fumes, vapors, dust, and a variety of other irritants, including exposure to human remains, as well as many severe psychological stressors, and the devastation to the World Trade Center site itself; and

Whereas, There are many Americans who now live with September 11 related medical and mental health conditions as well as those whose lives were prematurely shortened because of the impact of these toxic exposures; and

Whereas, The effects of the 9/11 attack have forever altered the world in every aspect of life from mental, emotional, medical, business, security, education, etc.; and

Whereas, Every American and every individual has felt the impact from lost loved ones who were taken away too early, or from the increased security and vigilance needed to protect this country; and

Whereas, Every life lost on that day represents the freedoms for which we were attacked; and

Whereas, *Patriot Day, 9/11*, is already recognized as a day of remembrance; and

Whereas, The terror attack on US soil on September 11, 2001 should never be minimized or forgotten; and

Whereas, The United States Congress holds the authority to create a Federal Holiday according to Title V of the United States Code (5 U.S.C. 6103); therefore be it

RESOLVED, That our American Medical Association support and recognize September 11th as an annual day of observance to remember and recognize all who died and who continue to suffer health consequences from the events of 9/11, to honor first- and all responders from around the country, and to recognize and forever remind us of the unity our country experienced on 9/11/01 and the months that followed. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000
Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(A-22)

Introduced by: New York

Subject: UN International Radionuclide Therapy Day Recognition

Referred to: Reference Committee F

Whereas, The General Assembly of the United Nations advocates for proclaiming International days of recognition to highlight specific values of worldwide human interest; and

Whereas, The United Nations General Assembly documents describe the purpose of proclaiming “International Days” as follows: “International days are occasions to educate the general public on issues of concern, to mobilize political will and resources to address global problems, and to celebrate and reinforce achievements of humanity”; and

Whereas, The year marks the 80th year from the first recorded use of radioiodine therapy to treat human disease; and

Whereas, Saul Hertz, MD (1905 - 1950) discovered the medical uses of radionuclides, and his breakthrough work with radioactive iodine (RAI) created a dynamic paradigm change integrating the sciences of physics, biology, physiology and medicine; and

Whereas, Radioactive iodine (RAI) is the first and remains the Gold Standard of targeted cancer therapies; and

Whereas, In early 1941, Dr. Hertz administered the first therapeutic treatment of (Cyclotron-produced) radioactive iodine (RAI) at the Massachusetts General Hospital, which led to the first series of twenty-nine patients with hyperthyroidism being treated successfully with RAI; and

Whereas, Dr. Hertz expanded the successful use of RAI of treating hyperthyroidism and Graves‘ disease to the treatment of thyroid cancer in 1946; and

Whereas, This work generating and utilizing radioactive material for medical therapy leaves an enduring legacy, impacting countless generations of patients, numerous institutions worldwide and setting the cornerstone for the field of Nuclear Medicine, and has for all future generations, augmented and forever altered the approach to medical therapies; and

Whereas, This novel work marks the advent of what we now recognize as modern medicine, utilizing molecular medicine and the ever evolving promise of targeted molecular therapies for the treatment of human disease; and

Whereas, To appropriately recognize and honor this groundbreaking scientific and medical breakthrough on its 80th year anniversary, and to honor Dr. Saul Hertz and to remember and celebrate this extraordinary accomplishment; therefore be it

RESOLVED, That our American Medical Association support the efforts of the American College of Nuclear Medicine to create and introduce a United Nations General Assembly (UNGA) Resolution for the creation of a new International Day of recognition with the suggested name of “International Radionuclide Therapy Day.” (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 03/22/22

Hertz B. A tribute to Dr. Saul Hertz: The discovery of the medical uses of radioiodine. *World J Nucl Med*. 2019;18(1):8-12. doi:10.4103/wjnm.WJNM_107_18
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Radioactive Iodine in the Study of Thyroid Physiology. VII. The Use of Radioactive Iodine Therapy in Graves' Disease. (Dec. 1946)
http://saulhertzmd.com/home

TABLE I AN ANALYSIS OF CASES "NOT CURED" BY Ra-I + KI (TO MARCH - '46)

SERIES NO.	CASE-HOSP. NO.	BMR PRIOR TO I 130	DOSAGE OF I 130 and DATES OF ADMINISTRATION	BMR PRIOR TO SUB-TOTAL THYROIDECT.	POST-OP BMR	THYROID WEIGHT	HISTOLOGY	TOTAL THYROID IRRADIATION (m) 12 HR	9 DAY	ESTIMATED THYROID WT. BEFORE I 130	% OF Ra-I (URINE) EXCRETED - 72 HRS. FOLLOWING THE ADMINISTRATION OF I 130
1	ELIZABETH D.	+30	2.1 mC 3-31-41, 1.3 mC 4-16-41 } 3.4 mC	(-3)(-7)	(-29)	34	INVOLUTION	470 220	660 240	35	20 28
5		+35	5.7 mC 7-16-'41	PLANNED EXPERIMENT	(-20)	31	HYPERPLASIA NO INVOL.	1000	1150	40	27
10		+55	0.7 mC 2-2-'42	(+3)	(-26)	26, 30 } 56	HYPERPLASIA MOD. INVOL.	120	80	60	38
14		+50	1.5 mC 7-13-'42	(-15)	(-24)	55	HYPERPLASIA + INVOLUTION	650	—	60	71
16		+25	1.0 mC 8-11-'42	(-8)	(-24)	28	INVOLUTION	1800	—	45	6
19		+65	1.5 mC 8-25-'42, 8 mC 3-8-'43, 5 mC 3-9-'43 } 28 mC	(+8) TO (+13)	(+36) TO (-18)	35	SL. HYPERPLASIA + INVOLUTION	2000 1500	—	60	9 15 7
2		+35	1.4 mC 5-10-'41, 0.9 mC '41, 2.4 mC '42, 0.8 mC '42 } 5.6 mC	NOT OPERATED ← PERSISTENT THYROTOXICOSIS ANOTHER 20 mC PROPOSED				160 110 120 100	140 100 120 100	40	54* 48 78 --
4		+30	3.6 mC 7-14-'41, 2.2 mC 7-31-'41 } 5.8 mC	← EYES BETTER. NO GOITER. BMR (+2) OFF MED. - 4 YRS.				270 170	300 180	60	55 56
3		+50	3.4 mC 6-6-'41	REMISSION FOR 1 YR - THEN				430	410	45	45
			20 mC 1-9-'46	(RECENTLY FOR TRUE RECURRENCE)				4300	—	30 (RECURRENCE)	35

a

* OPHTHALMOPATHIC TYPE

TABLE II - ANALYSIS OF 20 CASES "CURED" BY Ra-I + KI ON BASIS OF EXAMINATION MARCH 31, 1946

SERIES NO.	CASE-HOSP. NO.	DOSE OF I 130 and DATE OF ADMINISTRATION	BMR BEFORE I 130	BMR LEVEL OFF IODIDES	TIME OFF IODIDES	THYROID SIZE '46	ESTIMATED THYROID WT. (Gm.)	% OF Ra-I EXCRETED 72-HOURS	ESTIMATED THYROID IRRADIATION (m) 12 HOUR	9 DAYS*
6		2.3 mC 7-24-'41, 1.7 mC 7-30-'41 } 4.0 mC	+45	DEC. '42 (-9) MAY '43 (-16) JAN. '46 (-7)	4 YRS.+	N	45	35 22	320 280	390 300
7		(ET 9) 1.4 mC 2-19-'41, 1.5 mC 9-21-'41 } 2.9 mC	+65	1-8-'46 (-6)	4 YRS.	N	45	3 20 (?)	260 260 (?)	280 220 (?)
8		(ET 9) 1.5 mC 9-24-'41	+30	7-17-'45 (-3) 5-27-'46 (+4)	7 MOS	FIRM 2 X N	40	15	300	250
9		4.9 mC 11-26-'41	+30	5-8-'45 (-10)	4 YRS.	N	60	17	650	420
11		5.8 mC 4-9-'42	+37	7-9-'42 (-12) 2-24-'44 (+9) 2-3-'46 (-13)	3.5 YRS.	N	60	17	750	380
12		7.5 mC 5-15-'42	+55	'45 (+11) 2-3-'46 (-13)	3 YRS.	HARD 1.5 X N	60-75	26	950	500
13		12 mC 6-9-'42	+30	3-'43 (+6) 2-3-'46 (-10)	3 YRS.	N	40	71	750	
15		6 mC 8-11-'42, 4 mC 8-11-'42 } 10 mC	+35	4-'45 (-6) 2-3-'46 (+2)	10 MOS.	N	40	10	2000	
17		13 mC 8-13-'42	+50	6-10-'44 (-15) 1-6-'46 (-9)	3 YRS.+	N	60	14	1300	
18		10.5 mC 8-15-42	+35	8-22-'44 (-10) 2-16-'46 (+1)	3 YRS.+	N	40	15	2000	
20		10 mC 11-14-'42	+50	4-5-'45 (-1) 2-16-'46 (-5)	2 YRS.+	N	45	20	1600	
21		14 mC 11-20-'42	+45	1-8-'46 (-13)	3 YRS.+	N	50	15 (?)	2000	
22		13 mC 3-9-'43	+20	6-30-'43 (-8)	2 YRS.+	?N (LMD.)	55	33	2200	
23		8 mC 3-15-'43, 10 mC 3-16-'43 } 18 mC	+55	6-9-'43 (-11) 2-16-'46 (-3)	2 YRS.+	FIRM 1.5 X N	75	76 67	500	
24		10.5 mC 3-26-'43, 4.5 mC 3-27-'43 } 15 mC	+40	12-'45 (-5)	2 YRS.+	N (DR. J.C.) (ZILHARDT)	50	57? 31	1000	
25		16 mC 4-2-'43	+44	9-28-'44 (-7) 4-27-'45 (+9) 3-20-'46 (+4)	2 YRS.+	N (DR. J.C.) (AUG)	50	20.6 63.0	750	
26		12 mC 4-6-'43	+39	'45 (-8) 1-16-'46 (+2)	2 YRS.+	N	45	85	350	
27		13 mC 4-12-'43	+40	7-17-'45 (-16) 2-15-'46 (-10)	2 YRS.+	N	50	33	1600	
28		10.5 mC 4-13-'43, 11.0 mC 4-13-'43 } 21 mC	+55	12-'45 (-15) 2-3-'46 (+6)	2 YRS+	N	75	---?	2000	
29		8 mC 3-29-'43, 4 mC 3-30-'43 } 12 mC	+30	2-'46 (+4)	2 YRS+	N	55	10 53 (?)	1200 250	

* 8 DAY ISOTOPE FIGURES ASSUME NO LOSS OF IODINE FROM THYROID DURING DECAY; THEY ARE THEREFORE EXCESSIVE. THEY WERE NOT MEASURED FOR CASES 13-29 —

b

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(A-22)

Introduced by: Resident and Fellow Section

Subject: Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis

Referred to: Reference Committee F

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1 Whereas, The Lancet Countdown on health and climate change has warned that "a rapidly
2 changing climate has dire implications for every aspect of human life, exposing vulnerable
3 populations to extremes of weather, altering patterns of infectious disease, and compromising
4 food security, safe drinking water, and clean air"[1] earning it the title of the "greatest public health
5 challenge of the 21st century"[2]; and
6
7 Whereas, Human activities since the Industrial Revolution resulting in burning fossil fuels like
8 coal and oil have increased the concentration of atmospheric carbon dioxide levels[3] higher than
9 ever before since the evolution of homo sapiens[4]; and
10
11 Whereas, At least 250,000 additional deaths are anticipated annually between 2030 and 2050
12 from heat exposure in the elderly, diarrhea, malaria, and childhood malnutrition alone[5], without
13 factoring in the myriad of other ways that climate change acts as a health risk multiplier; and
14
15 Whereas, Despite the landmark Paris Agreement in 2016, when countries committed to limit
16 global warming to "well below 2°C," global carbon dioxide (CO2) emissions continue to rise
17 steadily[6], with no convincing or sustained abatement; and
18
19 Whereas, Humans have already caused a rise in the global average temperature of 1.2°C and
20 our changing climate is already producing considerable shifts in the underlying social and
21 environmental determinants of health at the global level[7]; and
22
23 Whereas, People and communities are differentially exposed to hazards and disproportionately
24 affected by climate-related health risks; for example, some populations might experience
25 increased climate risks due to a combination of exposure and sensitivity, such as outdoor
26 workers[8], communities disproportionately burdened by poor environmental quality[9], and some
27 communities in the rural Southeastern United States[10]; and
28
29 Whereas, Across all climate risks, children, older adults, low-income communities, some
30 communities of color, and those experiencing discrimination are disproportionately affected by
31 extreme weather and climate events, partially because they are often excluded in planning
32 processes[11]; and
33
34 Whereas, According to the latest available science, in order to limit warming to 1.5°C and
35 achieve the Paris Agreement goals would require global greenhouse gas (GHG) emissions to
36 have peaked by 2020 and be reduced to zero by around 2050[12]; thus we have a vanishing
37 window of opportunity for meaningful action; and

Whereas, Many climate change mitigation interventions have immediate local air quality benefits, among others, and thus immediate health co-benefits[13]; and

Whereas, Cutting GHG emissions "may appear to be difficult and costly, but its near-term benefits outweigh its costs in many areas[14]; and

Whereas, It is estimated that worldwide 10.2 million premature deaths annually are attributable to the fossil-fuel component of PM2.5, constituting nearly 18% of premature deaths[15]; and

Whereas, Worldwide, tobacco use causes more than seven million deaths per year[16]; and

Whereas, Our AMA has extensive policy to organize physician leadership vis a vis tobacco's public health harms[17]; and

Whereas, The Tobacco Industry and Fossil Fuel Industry business models are similar in that their products are incongruous with the interests of public health and their profit interests motivate well-funded misinformation campaigns[18]; and

Whereas, "The strategy, tactics, infrastructure, and rhetorical arguments and techniques used by fossil fuel interests to challenge the scientific evidence of climate change—including cherry picking, fake experts, and conspiracy theories—come straight out of the Tobacco Industry's playbook for delaying tobacco control"[19]; and

Whereas, Physicians are uniquely trusted messengers, with a unique responsibility to advocate politically for policies to safeguard health in the face of any public health crisis, whether the COVID-19 pandemic or the climate crisis, in order to build social will for science-based policy action; and

Whereas, Our AMA has adopted multiple policies addressing climate change (H-135.919, H-135.938, H-135.977, H-135.923, D-135.968,D-135.969, H-135.973), but these policies fall short of coordinating strategic physician advocacy leadership on the scale necessary for such a health crisis; and

Whereas, In the face of the existential threat that the climate crisis poses, the aforementioned policies have not been leveraged to fulfill our AMA's Declaration of Professional Responsibility (H-140.900) which states, "We, the members of the world community of physicians, solemnly commit ourselves to 'Medicine's Social Contract with Humanity' in order to continue to earn society's trust in the healing profession, by, among other oaths, promising that we will 'Educate the public and polity about present and future threats to the health of humanity''; and

Whereas, Our AMA has no identified longitudinal body or Center for coordinating and centralizing the Association's efforts to address climate change which the WHO calls "...the greatest threat to global health in the 21st century"'[20]; and

Whereas, Our AMA Corporate Policies on Tobacco H-500.975: resolved that (1) Our AMA: (a) continues to urge the federal government to reduce and control the use of tobacco and tobacco products; (b) supports developing an appropriate body for coordinating and centralizing the Association's efforts toward a tobacco-free society; and (c) will defend vigorously all attacks by the tobacco industry on the scientific integrity of AMA publications; therefore be it

RESOLVED, That our American Medical Association reaffirm Policy H-135.949, "Support of Clean Air and Reduction in Power Plant Emissions," (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA establish a climate crisis campaign that will distribute evidence-based information on the relationship between climate change and human health, determine high-yield advocacy and leadership opportunities for physicians, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050. (Directive to Take Action)

Fiscal Note: Pending

Received: 04/04/22

The topic of this resolution is currently under study by the Council on Science and Public Health.

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RELEVANT AMA POLICY

Support of Clean Air and Reduction in Power Plant Emissions H-135.949
Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.
Citation: Res. 429, A-03; Reaffirmation I-07; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Modified: Res. 506, A-15; Modified: Res. 908, I-17

Climate Change Education Across the Medical Education Continuum H-135.919
Our AMA: (1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education.
Citation: Res. 302, A-19

Global Climate Change and Human Health H-135.938
Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19

Global Climate Change – The "Greenhouse Effect" H-135.977
Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting;
(2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;
(3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity;
(4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and
(5) encourages humanitarian measures to limit the burgeoning increase in world population.
Citation: CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
Citation: Res. 924, I-16; Reaffirmation: I-19

Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Health Care Leadership D-135.968
Our AMA will continue to explore environmentally sustainable practices for *JAMA* distribution.
Citation: BOT Rep. 8, I-19

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies D-135.969
Our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels.
Citation: BOT Rep. 34, A-18

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from

global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.
Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(A-22)

Introduced by: Michigan

Subject: Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology® System

Referred to: Reference Committee F

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1 Whereas, The COVID-19 pandemic and restrictions brought unprecedented financial strain
2 upon physicians, with the most recent Physician Foundation survey showing 12 percent of
3 physicians either closing or planning to close their practice within the next year (75 percent of
4 those physicians are in private practice), and nearly 75 percent of physicians reported lost
5 income; and
6
7 Whereas, During this time, physicians also had to implement the new Current Procedural
8 Terminology® (CPT®) Evaluation and Management (E/M) code revisions, which became
9 effective January 1, 2021; and
10
11 Whereas, This was the first major change to the codes and guidelines for office and other
12 outpatient evaluation and management (E/M) services in 24 years; and
13
14 Whereas, Although the Centers for Medicare and Medicaid Services (CMS) signaled its intent to
15 update E/M coding and documentation guidelines when it requested stakeholder feedback in
16 the proposed 2017 Medicare Physician Fee Schedule rules and continued to propose updates
17 in future rules, some stakeholders were hopeful for a delay as physicians were still reeling from
18 the pandemic; and
19
20 Whereas, Given that each patient encounter and experience is unique, medical coding system
21 to accurately reflect the care given within hundreds of specialties and thousands of patient visits
22 may be difficult or have a disparate impact on physicians in different specialties; and
23
24 Whereas, The AMA reported that when the revisions became effective, the AMA received
25 feedback on areas causing confusion, in response to which the CPT Editorial Panel issued
26 technical corrections to add clarity and answer questions concerning the E/M code revisions;
27 and
28
29 Whereas, The intent of these E/M coding changes--to modernize billing and documentation,
30 reduce administrative burdens on physicians, and recognize time spent evaluating and managing
31 patients' care--is commendable; however, actual experiences and consequences should be
32 studied and modified as necessary to further simplify E/M documentation and ease
33 administrative burdens and to fairly and accurately reflect the evaluation and management
34 services provided by private and employed physicians, reflective of the complexity of care within
35 all specialties, and respectful of uncompensated care by our specialist colleagues; therefore be it

1 RESOLVED, That our American Medical Association survey physicians about and study the
2 impact of the 2021 CPT® Evaluation and Management coding reform on physicians, among all
3 specialties, in private and employed practices and report the findings and any recommendations
4 at the November 2022 meeting of the House of Delegates. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

Source:
1. http://physiciansfoundation.org/wp-content/uploads/2020/08/20-1278-Merritt-Hawkins-2020-Physicians-Foundation-Survey.6.pdf

RELEVANT AMA POLICY

AMA CPT Editorial Panel and Process H-70.973
The AMA will continue (1) to work to improve the CPT process by encouraging specialty societies to participate fully in the CPT process; (2) to enhance communications with specialty societies concerning the CPT process and subsequent appeals process; and (3) to assist specialty societies, as requested, in the education of their members concerning CPT coding issues.
Citation: Sub. Res. 806, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmation: I-17

Preservation of Evaluation/Management CPT Codes H-70.985
It is the policy of the AMA to (1) oppose the bundling of procedure and laboratory services within the current CPT Evaluation/Management (E/M) services;
(2) oppose the compression of E/M codes and support efforts to better define and delineate such services and their codes;
(3) seek feedback from its members on insurance practices that advocate bundling of procedures and laboratory services with or the compression of codes in the CPT E/M codes, and express its views to such companies on behalf of its members;
(4) continue to work with the PPRC and all other appropriate organizations to insure that any modifications of CPT E/M codes are appropriate, clinically meaningful, and reflective of the considered views of organized medicine; and
(5) work to ensure that physicians have the continued opportunity to use CPT as a coding system that is maintained by the medical profession.
Citation: Sub. Res. 98, A-90; Reaffirmed by Res. 850, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

Use of CPT Editorial Panel Process H-70.919
Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetic statements and modifiers.
Citation: BOT Rep. 4, A-06; Reaffirmation A-07; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation A-10; Reaffirmation A-11; Reaffirmation I-14; Reaffirmed: CMS Rep. 4, I-15; Reaffimation A-16; Reaffirmed in lieu of: Res. 117, A-16; Reaffirmed in lieu of: Res. 121, A-17; Reaffirmation: A-18; Reaffirmation: I-18; Reaffirmed: Res. 816, I-19

CPT Coding System H-70.974
1. The AMA supports the use of CPT by all third party payers and urges them to implement yearly changes to CPT on a timely basis.

2. Our AMA will work to ensure recognition of and payment for all CPT codes approved by the Centers for Medicare & Medicaid Services (CMS) retroactive to the date of their CMS approval, when the service is covered by a patient's insurance.
Citation: Sub. Res. 809, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Appended: Res. 803, I-11; Reaffirmed: CMS Rep. 1, A-21

Physicians' Current Procedural Terminology H-70.972
The AMA (1) continues to seek ways to increase its efforts to communicate with specialty societies and state medical associations concerning the actions and deliberations of the CPT Maintenance process; (2) urges the national medical specialty societies to ensure that their representatives to the CPT process are fully informed as to their association's policies and coding preferences; and (3) urges those specialty societies that have not nominated individuals to serve on the CPT Advisory Committee to do so.
Citation: BOT Rep. MM, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607
(A-22)

Introduced by: American Association of Public Health Physicians

Subject: AMA Urges Health and Life Insurers of Divest From Investments in Fossil Fuels

Referred to: Reference Committee F

Whereas, Our AMA recognizes the urgent, ongoing health threats posed to our patients by global climate change,[1,5] which on its current trajectory is likely to far exceed the health impacts of COVID19 and HIV combined; and

Whereas, Our AMA has declared "the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes"[1]; and

Whereas, In 2018, our AMA adopted policy that "AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels"[2]; and

Whereas, Many health and life insurance companies followed the example of the AMA by divesting from tobacco companies because the tobacco industry's products and marketing strategies so clearly threaten human health; and

Whereas, Moody's Investors Service warned investors in 2017 that the oil and gas industry faces significant credit risks due to the world's ongoing transition away from fossil fuel[3]; and

Whereas, The top 10 U.S. health insurers, ranked by U.S. market share and for whom there are publicly disclosed fossil fuel investment data, have invested nearly $24 billion dollars in fossil fuels companies;[4] and

Whereas, Collectively, the largest nineteen health or life insurance companies have declared investments of more than over $183 billion in the fossil fuel industry[4]; therefore be it

RESOLVED, That our American Medical Association declare that climate change is an urgent public health emergency, and calls upon all governments, organizations, and individuals to work to avert catastrophe (New HOD Policy); and be it further

RESOLVED, That our AMA urge all health and life insurance companies, including those that provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels (New HOD Policy); and be it further

1 RESOLVED, That our AMA send letters to the nineteen largest health or life insurance
2 companies in the United States to inform them of AMA policies concerned with climate change
3 and with fossil fuel divestments, and urging these companies to divest. (Directive to Take
4 Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/08/22

References:
1. AMA Policy H-135.938 Global Climate Change and Human Health
2. AMA Policies D-135.969 & H-135.921 AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies
3. https://www.moodys.com/research/Moodys-Significant-credit-risks-arise-for-oil-and-gas-industry--PR_365728 Accessed 4.30.2021
4. https://www.psr.org/wp-content/uploads/2020/10/running-out-of-time.pdf Accessed 4.30.2021

RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938

Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies D-135.969

Our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels.
Citation: BOT Rep. 34, A-18

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921

1. Our AMA will choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption.
2. Our AMA will support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.

Citation: BOT Rep. 34, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608
(A-22)

Introduced by: Resident and Fellow Section

Subject: Transparency of Resolution Fiscal Notes

Referred to: Reference Committee F

Whereas, AMA resolutions include a fiscal note to share the projected cost of the resolution resolved clauses, if adopted; and

Whereas, The fiscal note is often categorized minimal, modest or moderate or sometimes, more specifically states an estimated cost in dollars; and

Whereas, Little justification or detail is provided to explain fiscal notes; and

Whereas, Providing the rationale behind the fiscal note to the House of Delegates would promote understanding, transparency, standardization and enable the House to utilize the AMA's resources more judiciously; therefore be it

RESOLVED, That our American Medical Association amend current policy G-600.061, "Guidelines for Drafting a Resolution or Report," by addition and deletion to read as follows:

(d) A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of ~~the~~ any proposed ~~policy, program,~~ study or directive to take action shall be generated and published by AMA staff in consultation with the sponsor~~.~~ prior to its acceptance as business of the AMA House of Delegates. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in the AMA House of Delegates Handbook to justify each fiscal note~~. When the resolution or report is estimated to have a resource implication of $50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers~~ (such as travel, consulting fees, meeting costs, or mailing). No resolution or report that proposes ~~policies, programs,~~ studies or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy. (Modify Current HOD Policy)

Fiscal Note: Estimated cost to implement resolution is $5,810 annually.

Received: 04/08/22

RELEVANT AMA POLICY

Guidelines for Drafting a Resolution or Report G-600.061
Resolutions or reports with recommendations to the AMA House of Delegates shall meet the following guidelines:
1. When proposing new AMA policy or modification of existing policy, the resolution or report should meet the following criteria:

(a) The proposed policy should be stated as a broad guiding principle that sets forth the general philosophy of the Association on specific issues of concern to the medical profession;
(b) The proposed policy should be clearly identified at the end of the resolution or report;
(c) Recommendations for new or modified policy should include existing policy related to the subject as an appendix provided by the sponsor and supplemented as necessary by AMA staff. If a modification of existing policy is being proposed, the resolution or report should set out the pertinent text of the existing policy, citing the policy number from the AMA policy database, and clearly identify the proposed modification. Modifications should be indicated by underlining proposed new text and lining through any proposed text deletions. If adoption of the new or modified policy would render obsolete or supersede one or more existing policies, those existing policies as set out in the AMA policy database should be identified and recommended for rescission. Reminders of this requirement should be sent to all organizations represented in the House prior to the resolution submission deadline;
(d) A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of the proposed policy, program, or action shall be generated by AMA staff in consultation with the sponsor. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in each fiscal note. When the resolution or report is estimated to have a resource implication of $50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing). No resolution or report that proposes policies, programs, or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy.
2. When proposing to reaffirm existing policy, the resolution or report should contain a clear restatement of existing policy, citing the policy number from the AMA policy database.
3. When proposing to establish a directive, the resolution or report should include all elements required for establishing new policy as well as a clear statement of existing policy, citing the policy number from the AMA policy database, underlying the directive.
4. Reports responding to a referred resolution should include the resolves of that resolution in its original form or as last amended prior to the referral. Such reports should include a recommendation specific to the referred resolution. When a report is written in response to a directive, the report should sunset the directive calling for the report.
5. The House's action is limited to recommendations, conclusions, and policy statements at the end of report. While the supporting text of reports is filed and does not become policy, the House may correct factual errors in AMA reports, reword portions of a report that are objectionable, and rewrite portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible. The supporting texts of reports are filed.
6. All resolutions and reports should be written to include both "MD and DO," unless specifically applicable to one or the other.
7. Reports or resolutions should include, whenever possible or applicable, appropriate reference citations to facilitate independent review by delegates prior to policy development.
8. Each resolution resolve clause or report recommendation must be followed by a phrase, in parentheses, that indicates the nature and purpose of the resolve. These phrases are the following:
(a) New HOD Policy;
(b) Modify Current HOD Policy;
(c) Consolidate Existing HOD Policy;
(d) Modify Bylaws;
(e) Rescind HOD Policy;
(f) Reaffirm HOD Policy; or
(g) Directive to Take Action.
9. Our AMA's Board of Trustees, AMA councils, House of Delegates reference committees, and sponsors of resolutions will try, whenever possible, to make adjustments, additions, or elaborations of AMA policy positions by recommending modifications to existing AMA policy statements rather than creating new policy.
Citation: CLRPD Rep. 4, A-99; Modified by BOT Rep. 15, A-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 2, A-02; Modified: CLRPD Rep. 6, A-03; Reaffirmed: BOT Rep. 19, A-04; Appended: Res. 606, A-05; Appended: Res. 611, A-07; Modified: CCB/CLRPD Rep. 1, A-12; Modified: Speakers Rep., A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 609
(A-22)

Introduced by: Georgia

Subject: Surveillance Management System for Organized Medicine Policies and Reports

Referred to: Reference Committee F

Whereas, An essential function of organized medicine is to represent the voice of their members and patients; and

Whereas, Significant resources are spent in terms of time and money across the local, state and national levels of organized medicine in the formulation of a wide scope of policy resolutions; and

Whereas, These resolutions undergo extensive debate with resulting dismissal, passage or referral at the respective state and/or national levels; and

Whereas, Approved resolutions and reports fall across different areas of priority and action; and

Whereas, Given the volume of resolutions and reports, the vast majority of policy statements and/or recommendations fail to be effectively disseminated back to the local or state membership, in addition to our patients; and

Whereas, Given the volume of resolutions and reports there currently is no system in place to provide surveillance management of the eventual outcome for the respective resolution and/or report; and

Whereas, The lack of timely, transparent and effective communication of the work performed by organized medicine, including at state and national House of Delegates, likely contributes to the apathy, disengagement and/or lack of membership (including renewal) by physicians at the local and state levels; and

Whereas, The practice of medicine is subject to performance metrics, including process and outcome in addition to surveys of satisfaction and service; therefore be it

RESOLVED, That our American Medical Association develop a prioritization matrix across both global and reference committee specific areas of interest (Directive to Take Action); and be it further

RESOLVED, That our AMA develop a web-based surveillance management system, with pre-defined primary and/or secondary metrics, for resolutions and reports passed by their respective governance body (Directive to Take Action); and be it further

1 RESOLVED, That our AMA share previously approved metrics and results from the surveillance
2 management system at intervals deemed most appropriate to the state and local membership of
3 organized medicine, including where and when appropriate to their patients. (Directive to Take
4 Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/14/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 610
(A-22)

Introduced by: Senior Physicians Section

Subject: Making AMA Meetings Accessible

Referred to: Reference Committee F

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1 Whereas, AMA has as a major goal the reduction of health care disparities; and
2
3 Whereas, AMA's Code of Ethics Opinion 8.5 states that "physicians should: (h) strive to
4 increase the diversity of the physician workforce as a step toward reducing health care
5 disparities"; and
6
7 Whereas, The self-reported incidence of disability in the general US population is over 25%[1],
8 and this is likely an under-estimate for a variety of reasons; and up to 40% in those over 65[2],
9 while the self-reported incidence of disability in the US ***physician*** population is approximately
10 3.1%[3], which is undoubtedly an underestimate of the actual incidence, for a variety of historical
11 and social reasons; and
12
13 Whereas, Discrimination against various marginalized physician membership populations has
14 occurred in AMA throughout its history, and demographic surveys of AMA physician leadership
15 as required by Policy G-600.035 do not include questions regarding disability, so there is no
16 information in the CLRPD Report[4] on this important demographic variable amongst AMA
17 leaders; and
18
19 Whereas, Intentional inclusion of individuals with disabilities in all aspects of AMA leadership will
20 predictably lead to increased integration of persons with disabilities amongst members and
21 leaders, and increased awareness of the lived experience and worldviews of physicians and
22 patients with disabilities; and
23
24 Whereas, Provision of accommodations to promote full participation and accessibility by those
25 with disabilities is required by the ADA[5] of all large employers (including AMA) and regulatory
26 agencies and of places of public accommodation, extending even into internet accessibility; and
27
28 Whereas, On-site AMA meetings spread out through a variety of physical venues present
29 unique challenges to participants who are mobility impaired or have other disability related
30 impediments to participation; and
31
32 Whereas, AMA members who are experiencing temporary illness, injuries, caretaking
33 responsibilities, or travel or mobility limitations may be unable to participate physically in on-site
34 leadership meetings; and
35
36 Whereas, Pandemic exigency and non-disability related travel restriction has demonstrated the
37 ability of organization such as our AMA to develop mechanisms for holding virtual meetings; and

Whereas, Hybrid (meaning on-site AS WELL AS virtual) meetings are being held by many organizations during the transition from pandemic, demonstrating the capability of organizations to make appropriate accommodations for accessibility to all participants; therefore be it

RESOLVED, That all future American Medical Association meetings be structured to provide accommodations for members who are able to physically attend, but who need assistance in order to meaningfully participate (Directive to Take Action); and be it further

RESOLVED, That our AMA investigate ways of allowing meaningful participation in all meetings of the AMA by members who are limited in their ability to physically attend meetings (Directive to Take Action); and be it further

RESOLVED, That our AMA revisit our criteria for selection of hotels and other venues for the HOD in order to facilitate maximum participation by members with disabilities (Directive to Take Action); and be it further

RESOLVED, That our AMA report back to the HOD by no later than the 2023 Annual Meeting with a plan on how to maximize HOD meeting participation for members with disabilities. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/03/22

REFERENCES

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2. Centers for Disease Control and Prevention. Disability Impacts All of Us, https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html (Retrieved April 6, 2022).
3. Nouri, Z., Dill, M. J., Conrad, S. S., Moreland, C. J., & Meeks, L. M. (2021). Estimated prevalence of US physicians with disabilities. *JAMA network open*, *4*(3), e211254-e211254.
4. Demographic characteristics of the House of Delegates and AMA leadership. Report of the Council on Long Range Planning and Development. CLRPD Report 01-JUN-21. American Medical Association; 2021. Retrieved May 3, 2022. Report of the Council on Long Range Planning and Development | AMA (ama-assn.org)
5. ADA (Americans With Disabilities Act) of 1990. Public Law 101-336. 108th Congress, 2nd session (July 26, 1990) and Amendments. https://www.ada.gov/pubs/adastatute08.htm (Retrieved May 2, 2022).

RELEVANT AMA POLICY

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 patientsclinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.
This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.
To fulfill this professional obligation in their individual practices physicians should:
(a) Provide care that meets patient needs and respects patient preferences.
(b) Avoid stereotyping patients.
(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.
The medical profession has an ethical responsibility to:
(g) Help increase awareness of health care disparities.
(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.
AMA Principles of Medical Ethics: I,IV,VII,VIII,IX
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

The Demographics of the House of Delegates G-600.035
1. A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.
2. As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year.
3. Future reports on the demographic characteristics of the House of Delegates should, whenever possible, identify and include information on successful initiatives and best practices to promote diversity within state and specialty society delegations.
Citation: CCB/CLRPD Rep. 3, A-12; Appended: Res. 616, A-14; Appended: CLRPD Rep. 1, I-15; Modified: Speakers Rep., I-17; Modified: BOT Rep. 27, A-19

Advocacy for Physicians and Medical Students with Disabilities D-615.977
Our AMA will: (1) establish an advisory group composed of AMA members who themselves have a disability to ensure additional opportunities for including physicians and medical students with disabilities in all AMA activities; (2) promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent; (3) develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians and medical students to manage their own disability-related needs in the workplace; and (4) communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws

protections and reasonable accommodations for physicians and medical students with visible and invisible disabilities.
Citation: BOT Rep. 19, I-21

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.
Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21

Advocacy for Physicians with Disabilities D-90.991
1. Our AMA will identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable physicians with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration.
2. Our AMA supports physicians and physicians-in-training education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities.
Citation: Res. 617, A-19; Reaffirmed: CME Rep. 2, I-21; Modified: BOT Rep. 19, I-21

Reference Committee G

BOT Report(s)

18 Addressing Inflammatory and Untruthful Online Ratings

CMS Report(s)

01 Council on Medical Service Sunset Review of 2012 House Policies
02 Prospective Payment Model Best Practices for Independent Private Practice
05 Poverty-Level Wages and Health

Resolution(s)

701 Appeals and Denial - CPT Codes for Fair Compensation
702 Health System Consolidation
703 Mandatory Reporting of All Antipsychotic Drug Use in Nursing Home Residents
704 Employed Physician Contracts
705 Fifteen Month Lab Standing Orders
706 Government Imposed Volume Requirements for Credentialing
707 Insurance Coverage for Scalp Cooling (Cold Cap) Therapy
708 Physician Burnout is an OSHA Issue
709 Physician Well-Being as an Indicator of Health System Quality
710 Prior Authorization - CPT Codes for Fair Compensation
711 Reducing Prior Authorization Burden
712 The Quadruple Aim - Promoting Improvement in the Physician Experience of Providing Care
713 Enforcement of Administrative Simplification Requirements
714 Prior Authorization Reform for Specialty Medications
715 Prior Authorization - CPT Codes for Fair Compensation
716 Discharge Summary Reform
717 Expanding the AMA's Study on the Economic Impact of COVID-19
718 Degradation of Medical Records
719 System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access
720 Mitigating the Negative Impact of Step Therapy Policies and Nonmedical Switching of Prescription Drugs on Patient Safety
721 Amend AMA Policy H-215.981 Corporate Practice of Medicine
722 Eliminating Claims Data for Measuring Physician and Hospital Quality

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-A-22

Subject: Addressing Inflammatory and Untruthful Online Ratings (Resolution 702-Jun-21)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee G

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

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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 physicians[1], 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 probation[7], 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 article[15] 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; and (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. (Directive to Take Action)

Fiscal Note: Less than $1000

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-22

Subject: Council on Medical Service Sunset Review of 2012 House Policies

Presented by: Asa C. Lockhart, MD, Chair

Referred to: Reference Committee G

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

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

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

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

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

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

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

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RECOMMENDATION

1 The Council on Medical Service recommends that the House of Delegates policies that are
2 listed in the appendix to this report be acted upon in the manner indicated and the
3 remainder of this report be filed.

APPENDIX – Recommended Actions

Policy #	Title	Text	Recommendation
D-165.957	State Options to Improve Coverage for the Poor	Our AMA (1) urges national medical specialty societies, state medical associations, and county medical societies to become actively involved in and support state-based demonstration projects to expand health insurance coverage to low-income persons; and (2) encourages state governments to maintain an inventory of private health plans and design an easily accessible, consumer-friendly information clearinghouse for individuals, families, and small businesses on available plans for expanding health insurance coverage. (CMS Rep. 1, A-05; Reaffirmed in lieu of Res. 105, A-12)	Rescind. Superseded by Policies D-165.942 and H-165.839, which state: Empowering State Choice D-165.942 Our AMA will advocate that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions. Health Insurance Exchange Authority and Operation H-165.839 1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges: A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from

Policy #	Title	Text	Recommendation
			patients and actively practicing physicians. C) Physician and patient decisions should drive the treatment of individual patients. D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options. E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process. F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices. 2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of

Policy #	Title	Text	Recommendation
			health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.
D-165.974	Achieving Health Care Coverage for All	Achieving Health Care Coverage for All -- Our American Medical Association joins with interested medical specialty societies and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States consistent with relevant AMA policy. (Res. 733, I-02; Modified: CCB/CLRPD Rep. 4, A-12)	Rescind. Superseded by Policy H-165.838, which states: 1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: a. Health insurance coverage for all Americans b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials d. Investments and incentives for quality improvement and prevention and wellness initiatives e. Repeal of the Medicare physician payment formula that triggers steep cuts and

Policy #	Title	Text	Recommendation
			threaten seniors' access to care f. Implementation of medical liability reforms to reduce the cost of defensive medicine g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens 2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation. 3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States. 4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. 5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians. 6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to

Policy #	Title	Text	Recommendation
			privately contract, without penalty to patient or physician. 7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals. 8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation: a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate

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			e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest 9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy. 10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform. 11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal. 12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform. 13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system

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			should be part of any national health system reform.
D-185.985	Patient Access to Therapeutics	Our AMA will work with other interested parties to ensure that payment for prescription medications and durable medical equipment not be denied based solely on the use of a properly suffixed institutional Drug Enforcement Agency number or similar identifier. (Res. 121, A-12)	Retain. Still relevant.
D-260.995	Improvements to Reporting of Clinical Laboratory Results	1. Our AMA will: (a) make its involvement with the Office of the National Coordinator for Health Information Technology and its Health Information Technology Policy and Standards Committees a high priority; and (b) become involved in and/or provide input into policies involving electronic transmission of clinical laboratory results. 2. Our AMA will encourage the College of American Pathologists, Health Level 7, the National Institute for Standards and Technology, and the Agency for Healthcare Research and Quality to urgently address usability and standardization of laboratory report results for physicians and non-physician practitioners to ensure patient safety. 3. Our AMA will support the continued efforts of relevant national medical specialty societies, such as the American College of Radiology, the American Osteopathic College of Radiology and other like organizations whose members generate reports electronically to clarify terminology and work in consultation with physicians likely to be end users toward producing a standardized format with appropriate standard setting bodies for the presentation of radiology results, including clearly identifiable diagnoses and test results. 4. Our AMA will report back to the House of Delegates on progress with regard to medical record and reporting standardization. (BOT Rep. 16, I-06; Modified: CMS Rep. 2, I-12)	Retain-in-part. The following subsection was accomplished and should be rescinded. 4. Our AMA will report back to the House of Delegates on progress with regard to medical record and reporting standardization.
D-285.965	Small Businesses and Health Reform	Our AMA will: (1) advocate that stop-loss coverage of self-insured plans have minimum attachment points that are high enough to ensure the adequacy	Retain. Still relevant.

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		and financial security of health insurance coverage of enrollees, and be provided by stop-loss insurers that are legitimate and financially secure and solvent; and (2) encourage states to monitor the rate at which small employers self-insure, and the impact of such self-insurance on the viability and purchasing power on SHOP exchanges. (CMS Rep. 6, A-12)	
D-290.980	Medicare-Medicaid Dual Eligible Demonstration Program	1. Our AMA will advocate that the Centers for Medicare & Medicaid Services and the states delay implementation of the Medicare-Medicaid dual eligible demonstration program for at least one year to allow beneficiaries and provider stakeholders to better understand and evaluate and comment on the "State Demonstrations to Integrate Care for Dual Eligible Individuals" initiative. 2. Because Medicare-Medicaid dual eligibles often have complex medical and social needs, our AMA will advocate to CMS and the states that established patient-provider relationships and current treatment plans will not be disrupted by the dual eligible Financial Alignment Initiative so as to preserve robust, patient-centered continuity of care. 3. Our AMA will advocate to CMS and the states that the Medicare-Medicaid dual eligibles Financial Alignment Initiative should operate as a true demonstration program, and therefore it should not enroll a majority of dual eligibles in any state, and there must be a rigorous evaluation plan to be consistent with the design of a demonstration that can provide useful information to policymakers. 4. Our AMA will advocate to CMS and states against automatically enrolling Medicare-Medicaid dual eligibles in a coordinated care program without their prior approval or consent. 5. Our AMA will work with CMS and the states to ensure that the Medicare-Medicaid dual eligibles Financial Alignment Initiative demonstrates potential ways of achieving efficiencies in organizing the care of dual eligibles, and any savings from coordination of care to dual eligibles should arise from	Retain-in-part. The following subsection is out-of-date and should be rescinded. The Centers for Medicare & Medicaid (CMS) has been implementing demonstration programs for dually eligible enrollees, including Financial Alignment Initiative demonstrations, since 2012. 1. Our AMA will advocate that the Centers for Medicare & Medicaid Services and the states delay implementation of the Medicare-Medicaid dual eligible demonstration program for at least one year to allow beneficiaries and provider stakeholders to better understand and evaluate and comment on the "State Demonstrations to Integrate Care for Dual Eligible Individuals" initiative.

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		better health outcomes and efficiencies gained by reducing duplicative, unnecessary, or inappropriate care. The Initiative should not be employed as a policy lever simply to reduce provider payment rates, which could significantly harm beneficiary access. Res. 123, A-12	
D-290.986	Capitation of Medicaid Funding for Guam and Other US Territorial Possessions	The AMA will support: (1) Repeal of 42 USC 1308(f) and to allow Guam and other Territorial Possessions and Island Nations to participate in the Medicaid program on the same terms as the States, without capitation of matching funds; (2) Amending 42 USC 1396(d)(b)(2) by striking "50 per centum" and by inserting in lieu thereof: "determined in the same manner as such percentage is determined for the States under this subsection"; this will allow the Territories to participate in the Medicaid program on the same terms as the States; and (3) Federal legislative language introduced during the 107th Congress that has provisions equivalent to those included in H.R. 5126, introduced during the last Congress by Virgin Islands Delegate Donna Christensen, MD. (BOT Action in response to referred for decision Res. 215, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmation A-12)	Retain-in-part. The following subsection is out-of-date and should be rescinded. (3) Federal legislative language introduced during the 107th Congress that has provisions equivalent to those included in H.R. 5126, introduced during the last Congress by Virgin Islands Delegate Donna Christensen, MD.
D-330.918	Appropriateness of National Coverage Decisions	1. Our AMA will work with the national medical specialty societies and the Centers for Medicare and Medicaid Services (CMS) and their intermediaries to identify outdated coverage decisions that create obstacles to clinically appropriate patient care. 2. Our AMA will work with CMS to suspend recovery actions for technologies and treatments for which sufficient comparative effectiveness research or other quality evidence exists to update a National Coverage Determination (NCD) or Local Coverage Determination (LCD) to reflect the available scientific evidence and contemporary practice. (Sub. Res. 120, A-11; Reaffirmed in lieu of Res. 125, A-12)	Retain. Still relevant.

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D-373.995	Shared Decision Making Resource Centers	Our AMA will advocate for full funding for section 3506 of the Affordable Care Act. (Res. 812, I-12)	Retain. Still relevant.
D-385.959	Billing Codes for Filling Out Forms	Our AMA will lobby the Centers for Medicare & Medicaid Services and other national payers to reimburse those physicians who utilize billing code 99080 for filling out various forms requested by patients. (Res. 803, I-12)	Retain. Still relevant.
D-390.956	MedPAC Recommendations from June 15, 2011	1. Our AMA will oppose any policy that applies a payment reduction to professional component of diagnostic services where multiple imaging studies are interpreted by the same practitioner during the same session and will oppose any policy that reduces the physician work component of imaging and other diagnostic tests that are ordered and interpreted by the same practitioner. 2. Our AMA will: (A) actively support legislation to repeal the 25 percent multiple procedure payment reduction (MPPR) recently implemented by the Centers for Medicare & Medicaid Services (CMS) as part of its 2012 Fee Schedule; and (B) work to prevent further broadening of CMS MPPR proposals until thoroughly studied by CMS. (BOT action in response to referred for decision Res. 124, A-11; Appended: Res. 214, A-12)	Retain-in-part. The following subsection is out-of-date and should be rescinded. 2. Our AMA will: (A) actively support legislation to repeal the 25 percent multiple procedure payment reduction (MPPR) recently implemented by the Centers for Medicare & Medicaid Services (CMS) as part of its 2012 Fee Schedule; and (B) work to prevent further broadening of CMS MPPR proposals until thoroughly studied by CMS.
D-410.992	Evidence-Based Utilization of Services	Our AMA supports physician-led, evidence based, efforts to improve appropriate utilization of medical services and will educate member physicians, hospitals, health care leaders and patients about the need for physician-led, evidence based, efforts to improve appropriate utilization of medical services. Res. 815, I-12	Rescind. Superseded by Policy H-285.931. The Critical Role of Physicians in Health Plans and Integrated Delivery Systems H-285.931 Our AMA adopts the following organizational principles for physician involvement in health plans and integrated delivery systems (IDS): (1) Practicing physicians participating in a health plan/IDS must: (a) be involved in the selection and removal of their leaders who are involved in governance or who serve on a

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			council of advisors to the governing body or management; (b) be involved in the development of credentialing criteria, utilization management criteria, clinical practice guidelines, medical review criteria, and continuous quality improvement, and their leaders must be involved in the approval of these processes; (c) be accountable to their peers for professional decisions based on accepted standards of care and evidence-based medicine; (d) be involved in development of criteria used by the health plan in determining medical necessity and coverage decisions; and (e) have access to a due process system. (2) Representatives of the practicing physicians in a health plan/IDS must be the decision-makers in the credentialing and recredentialing process. (3) To maximize the opportunity for clinical integration and improvement in patient care, all of the specialties participating in a clinical process must be involved in the development of clinical practice guidelines and disease management protocols. (4) A health plan/IDS has the right to make coverage decisions, but practicing physicians participating in the health plan/IDS must be able to discuss treatment alternatives with their patients to enable them to make informed decisions. (5) Practicing physicians and patients of a health plan/IDS should have access to a

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			timely, expeditious internal appeals process. Physicians serving on an appeals panel should be practicing participants of the health plan/IDS, and they must have experience in the care under dispute. If the internal appeal is denied, a plan member should be able to appeal the medical necessity determination or coverage decision to an independent review organization. (6) The quality assessment process and peer review protections must extend to all sites of care, e.g., hospital, office, long-term care and home health care. (7) Representatives of the practicing physicians of a health plan/IDS must be involved in the design of the data collection systems and interpretation of the data so produced, to ensure that the information will be beneficial to physicians in their daily practice. All practicing physicians should receive appropriate, periodic, and comparative performance and utilization data. (8) To maximize the opportunity for improvement, practicing physicians who are involved in continuous quality improvement activities must have access to skilled resource people and information management systems that provide information on clinical performance, patient satisfaction, and health status. There must be physician/manager teams to identify, improve and document cost/quality relationships that demonstrate value. (9) Physician representatives/leaders must communicate key policies

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			and procedures to the practicing physicians who participate in the health plan/IDS. Participating physicians must have an identified process to access their physician representative. (10) Consideration should be given to compensating physician leaders/representatives involved in governance and management for their time away from practice. Our AMA aggressively advocates to private health care accreditation organizations the incorporation of the organizational principles for physician involvement into their standards for health plans, networks and integrated delivery systems.
D-410.993	Need to Include Assessment of Economic Impact in Practice Guidelines	Our AMA will continue to monitor the methodological guidance, data collection, and data synthesis applied to evaluating the economic impact of implementing guidelines into clinical practice. (BOT Rep. 13, A-12)	Retain. Still relevant.
H-35.996	Status and Utilization of New or Expanding Health Professionals in Hospitals	(1) The services of certain new health professionals, as well as those professionals assuming an expanded medical service role, may be made available for patient care within the limits of their skills and the scope of their authorized practice. The occupations concerned are those whose patient care activities involve medical diagnosis and treatment to such an extent that they meet the three criteria specified below: (a) As authorized by the medical staff, they function in a newly expanded medical support role to the physician in the provision of patient care. (b) They participate in the management of patients under the direct supervision or direction of a member of the medical staff who is responsible for the patient's care. (c) They make entries on patients' records, including progress notes, only to the extent established by the medical staff.	Retain. Still relevant.

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		Thus this statement covers regulation of such categories as the new physician-support occupations generically termed physician assistants, nurse practitioners, and those allied health professionals functioning in an expanded medical support role. (2) The hospital governing authority should depend primarily on the medical staff to recommend the extent of functions which may be delegated to, and services which may be provided by, members of these emerging or expanding health professions. To carry out this obligation, the following procedures should be established in medical staff bylaws: (a) Application for use of such professionals by medical staff members must be processed through the credentials committee or other medical staff channels in the same manner as applications for medical staff membership and privileges. (b) The functions delegated to and the services provided by such personnel should be considered and specified by the medical staff in each instance, and should be based upon the individual's professional training, experience, and demonstrated competency, and upon the physician's capability and competence to supervise such an assistant. (c) In those cases involving use by the physician of established health professionals functioning in an expanded medical support role, the organized medical staff should work closely with members of the appropriate discipline now employed in an administrative capacity by the hospital (for example, the director of nursing services) in delineating such functions. (BOT Rep. G, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified:CMS Rep. 6, A-10; Reaffirmation A-12)	
H-70.924	Litigation Center Cases to Combat Automatic Downcoding and/or Recoding	The Litigation Center continues to initiate or support lawsuits that seek redress from insurers who engage in inappropriate or inaccurate downcoding and/or recoding practices. (BOT Rep. 31, A-02; Reaffirmed:CMS Rep. 4,	Retain. Still relevant.

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H-70.925	CPT Editorial Panel Representation	(1) The CPT Editorial Panel shall be kept at a size compatible with its functioning as an efficient and effective editorial board and should not be subject to the requirement of formal slotted seats for individual specialty societies. (2) While the role of the CPT Advisory Committee as clinical and technical experts to the CPT Editorial Panel is important, necessary, and currently of satisfactory composition, the need to expand as the practice of medicine changes or the scope of the CPT code set changes should be regularly evaluated. (BOT Rep. 34,	Retain. Still relevant.
H-155.966	Controlling Cost of Medical Care	The AMA urges the American Hospital Association and all hospitals to encourage the administrators and medical directors to provide to the members of the medical staffs, house staff and medical students the charges for tests, procedures, medications and durable medical equipment in such a fashion as to emphasize cost and quality consciousness and to maximize the education of those who order these items as to their costs to the patient, to the hospital and to society in general. (Sub. Res. 75, I-81; Reaffirmed: CLRPD Rep. F, I-91; Res. 801, A-93;CMS Rep. 12, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed:CMS Rep. 8, A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 5, A-12)	Retain. Still relevant.
H-155.998	Voluntary Health Care Cost Containment	(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature. (2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. (3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including house staff officers, on all aspects of hospital charges, including specific medical	Retain. Still relevant.

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		tests, procedures, and all ancillary services. (4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum. (5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care. (6) All physicians, practicing solo or in groups, independently or in professional association, should review their professional charges and operating overhead with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs. (7) The AMA should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care. (Res. 34, A-78; Reaffirmed: CLRPD Rep. C, A-89; Res. 100, I-89; Res. 822, A-93; Reaffirmed: BOT Rep. 40, I-93;CMS Rep. 12, A-95; Reaffirmed: Res. 808, I-02; Modified:CMS Rep. 4, A-12)	
H-160.913	Medicaid Patient-Centered Medical Home Models	Our AMA: (1) recognizes that the physician-led medical home model, as described by Policy H-160.919, has demonstrated the potential to enhance the value of health care by improving access, quality and outcomes while reducing costs; and (2) will work with state medical associations to explore, and where feasible, implement physician-led Medicaid patient-centered medical home models based on the unique needs of the physicians and patients in their states. (CMS Rep. 3, A-12)	Retain. Still relevant.
H-160.914	Support of Multilingual Assessment Tools for	Our AMA will encourage the publication and validation of standard patient assessment tools in multiple languages. (Res. 703, A-12)	Retain. Still relevant.

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	Medical Professionals		
H-165.832	Basic Health Program	1. Our AMA supports the adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans to limit patient churn and promote the continuity and coordination of patient care. 2. Our AMA adopts the following principles for the establishment and operation of state Basic Health Programs: A. State Basic Health Programs (BHPs) should guarantee ample health plan choice by offering multiple standard health plan options to qualifying individuals. Standard health plans offered within a BHP should provide an array of choices in terms of benefits covered, cost-sharing levels, and other features. B. Standard health plans offered under state BHPs should offer enrollees provider networks that have an adequate number of contracted physicians and other health care providers in each specialty and geographic region. C. Standard health plans offered in state BHPs should include payment rates established through meaningful negotiations and contracts. D. State BHPs should not require provider participation, including as a condition of licensure. E. Actively practicing physicians should be significantly involved in the development of any policies or regulations addressing physician payment and practice in the BHP environment. F. State medical associations should be involved in the legislative and regulatory processes concerning state BHPs. G. State BHPs should conduct outreach and educational efforts directed toward physicians and their patients, with adequate support available to assist physicians with the implementation process. (CMS Rep. 5, A-12)	Retain. Still relevant.

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H-165.845	State Efforts to Expand Coverage to the Uninsured	Our AMA supports the following principles to guide in the evaluation of state health system reform proposals: 1. Health insurance coverage for state residents should be universal, continuous, and portable. Coverage should be mandatory only if health insurance subsidies are available for those living below a defined poverty level. 2. The health care system should emphasize patient choice of plans and health benefits, including mental health, which should be value-based. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as references when considering if a given plan would provide meaningful coverage. 3. The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable. 4. The administration and governance system should be simple, transparent, accountable, and efficient and effective in order to reduce administrative costs and maximize funding for patient care. 5. Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations. (CMS Rep. 3, I-07; Reaffirmed: Res. 239, A-12)	Rescind. Superseded by Policy D-165.942, which states: Our AMA will advocate that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions.
H-165.904	Universal Health Coverage	Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions	Retain. Still relevant.

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		providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans. (Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12)	
H-180.964	Health Care Coverage of Young Adults Under Their Parents' Family Policies	Our AMA encourages the health insurance industry, employers and health plans to make available to young adults who do not have health insurance extended family health expense coverage to age 28 that conforms to the following characteristics: (1) The option to extend coverage under the parents' family policy or plan from the usual cut-off age to age 28 should be available for a specified initial enrollment period beyond the usual cut-off age under the plan. (2) Enrollment in the family coverage other than during this initial period should be available without a preexisting condition limitation to those individuals (to age 28) seeking the coverage because of loss of previous insurance protection within a specified time after loss of the previous protection, and should be available with a preexisting condition limitation to those seeking the coverage for other reasons at any time. (3) Status as a full-time student should not be a requirement for extension of or first-time enrollment in the parents' coverage. (4) To the extent that premiums for such a plan are higher, the extended coverage should be made available as a separate extra-cost rider. (CMS Rep. 1, I-95; Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)	Retain. Still relevant.
H-180.978	Access to Affordable Health Care	Our AMA (1) through its coalition with business and industry and its state federation, supports giving priority	Rescind. Superseded by Policies H-165.846 and H-165.825, which state:

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	Insurance through Deregulation of State Mandated Benefits	attention to a partial and rational deregulation of the insurance industry in order to expand access to affordable health care coverage; and (2) reaffirms its commitment to private health care insurance using pluralistic, free enterprise mechanisms rather than government mandated and controlled programs. (Res. 129, A-89; Reaffirmed: CLRPD Rep. 2, I-99; Reaffirmed:CMS Rep. 5, A-09; Reaffirmed: Res. 239, A-12)	Adequacy of Health Insurance Coverage Options H-165.846 1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options: A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose. B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage. C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations. D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services. 2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children. 3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their

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			associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses. Ensuring Marketplace Competition and Health Plan Choice H-165.825 Our AMA will: (1) support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits; (2) oppose the sale of health insurance plans in the individual and small group markets that do not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months; and (3) support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation.
H-190.988	Medicare Claims Processing Accuracy	Our AMA will: (1) continue efforts to assure that Medicare carriers accurately process claims; (2) continue to pursue legislation to require local physician input on the adequacy of carrier performance; (3) continue to pursue legislation to allow individual physicians to request and receive an	Rescind. No longer relevant.

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		administrative law hearing to challenge carrier performance of administrative and other policy requirements; and (4) take other appropriate actions that will result in penalties for carriers that process claims inaccurately. (BOT Rep. C, A-92; Reaffirmed: Res. 712, A-02; Reaffirmed:CMS Rep. 4, A-12)	
H-210.989	Medicare Physician Reimbursement for Home Health Visits	It is the policy of the AMA: (1) to urge Congress and CMS to adjust reimbursement for physician home visits so that the payment made to physicians is consistent with the services involved in treating patients at home; and (2) that physician reimbursement should appropriately reflect the relative differences in the training and skill of physicians and other home health care providers. (Res. 109, A-91; Reaffirmation A-97: Reaffirmation I-99; Reaffirmation A-02; Reaffirmed:CMS Rep. 4, A-12)	Retain. Still relevant.
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. (BOT Rep. D, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed:CMS Rep. 7, A-11; Modified: Res. 702, A-12)	Rescind. Superseded by Policy H-160.924, which states: Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924 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

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			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-225.951	The Importance of Local Control of Hospitals	Our AMA will establish policy and advocate for local governing boards to continue to exist for individual hospitals within multi-hospital systems to ensure that community needs, the needs of local medical staff and patient care needs are met within those communities whenever possible. (Res. 719, A-12)	Retain. Still relevant.
H-225.964	Hospital Employed/Contracted Physicians Reimbursement	AMA policy states that: (1) all hospital employed/contracted physicians be prospectively involved if the hospital negotiates for them for capitation and global billing contracts; (2) hospital employed/contracted physicians be informed about the actual payment amount allocated to the physician component of the total hospital payment received by the contractual arrangement; and (3) all potential hospital/contracted physicians request a bona fide hospital plan which delineates the actual payment amount allocated to the employed or contracted physicians. (Sub. Res. 723, I-96; Reaffirmed: Res. 812, A-02; Reaffirmed:CMS Rep. 4, A-12; Reaffirmed: BOT Rep. 4, I-12)	Retain. Still relevant.
H-225.973	Financial Arrangements Between	Our AMA: (1) opposes financial arrangements between hospitals and physicians that are unrelated to professional services, or to the time,	Retain. Still relevant.

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	Hospitals and Physicians	skill, education and professional expertise of the physician; (2) opposes any requirement which states that fee-for-services payments to physicians must be shared with the hospital in exchange for clinical privileges; (3) opposes financial arrangements between hospitals and physicians that (a) either require physicians to compensate hospitals in excess of the fair market value of the services and resources that hospitals provide to physicians, (b) require physicians to compensate hospitals even at fair market value for hospital provided services that they neither require nor request, or (c) require physicians to accept compensation at less than the fair market value for the services that physicians provide to hospitals; (4) opposes financial arrangements between hospitals and pathologists that force pathologists to accept no or token payment for the medical direction and supervision of hospital-based clinical laboratories; and (5) urges state medical associations, HHS, the AHA and other hospital organizations to take actions to eliminate financial arrangements between hospitals and physicians that are in conflict with the anti-kickback statute of the Social Security Act, as well as with AMA policy. (CMS Rep. C, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed and Appended:CMS Rep. 2, I-02; Reaffirmed:CMS Rep. 4, A-12)	
H-285.923	Elimination of Mental Health and Chemical Dependency Carve-Outs	Our AMA opposes and will work to eliminate mental health and chemical dependency carve-outs. (Sub. Res. 702, I-00; Reaffirmed:CMS 7, A-02; Reaffirmed:CMS Rep. 4, A-12)	Rescind. Superseded by Policies H-185.974, D-180.998, H-95.914, D-110.987, and H- 385.915 which state: Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs H-185.974 Our AMA supports parity of coverage for mental illness, alcoholism, substance use, and eating disorders.

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			Insurance Parity for Mental Health and Psychiatry D-180.998 Our AMA in conjunction with the American Psychiatric Association and other interested organizations will develop model state legislation for the use of state medical associations and specialty societies to promote legislative changes assuring parity for the coverage of mental illness, alcoholism, and substance abuse. Opioid Mitigation H-95.914 Our AMA urges state and federal policymakers to enforce applicable mental health and substance use disorder parity laws. The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987 1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance. 2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight. 3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale. 4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those

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			related to discriminatory benefit design and mental health and substance use disorder parity. 5. Our AMA supports improved transparency of PBM operations, including disclosing: - Utilization information; - Rebate and discount information; - Financial incentive information; - Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy; - Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records; - Methodology and sources utilized to determine drug classification and multiple source generic pricing; and - Percentage of sole source contracts awarded annually. 6. Our AMA encourages increased transparency in how DIR fees are determined and calculated. Integrating Physical and Behavioral Health Care H-385.915 Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care

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			physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings.
H-285.956	Mental Health "Carve-Outs"	Our AMA is opposed to mental health carve-outs. However, in order to protect the large number of patients currently covered by carve-out arrangements, the AMA advocates that all managed care plans that provide or arrange for behavioral health care adhere to the following principles, and that any public or private entities that evaluate such plans for the purposes of certification or accreditation utilize these principles in conducting their evaluations: (1) Plans should assist participating primary care physicians to recognize and diagnose the behavioral disorders commonly seen in primary care practice. (2) Plans should reimburse qualified participating physicians in primary care and other non-psychiatric physician specialties for the behavioral health services provided to plan enrollees. (3) Plans should utilize practice guidelines developed by physicians in the appropriate specialties, with local adaptation by plan physicians as	Rescind. Superseded by Policies H-185.974, D-180.998, H-95.914, D-110.987, and H- 385.915 which state: Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs H-185.974 Our AMA supports parity of coverage for mental illness, alcoholism, substance use, and eating disorders. Insurance Parity for Mental Health and Psychiatry D-180.998 Our AMA in conjunction with the American Psychiatric Association and other interested organizations will develop model state legislation for the use of state

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		appropriate, to identify the clinical circumstances under which treatment by the primary care physician, direct referral to psychiatrists or other addiction medicine physicians, and referral back to the primary care physician for care of behavioral disorders is indicated, and should pay for all physician care provided in conformance with such guidelines. In the absence of such guidelines, direct referral by the primary care physician to the psychiatrist or other addiction medicine physician should be allowed when deemed necessary by the referring physician. (4) Plans should foster continuing and timely collaboration and communication between primary care physicians and psychiatrists in the care of patients with medical and psychiatric comorbidities. (5) Plans should encourage a disease management approach to care of behavioral health problems. (6) Participating health professionals should be able to appeal plan-imposed treatment restrictions on behalf of individual enrollees receiving behavioral health services, and should be afforded full due process in any resulting plan attempts at termination or restriction of contractual arrangements. (7) Plans using case managers and screeners to authorize access to behavioral health benefits should restrict performance of this function to appropriately trained and supervised health professionals who have the relevant and age group specific psychiatric or addiction medicine training, and not to lay individuals, and in order to protect the patient's privacy and confidentiality of patient medical records should elicit only the patient information necessary to confirm the need for behavioral health care. (8) Plans assuming risk for behavioral health care should consider "soft" capitation or other risk/reward-sharing mechanisms so as to reduce financial incentives for undertreatment. (9) Plans should conduct ongoing assessment of patient outcomes and	medical associations and specialty societies to promote legislative changes assuring parity for the coverage of mental illness, alcoholism, and substance abuse. Opioid Mitigation H-95.914 Our AMA urges state and federal policymakers to enforce applicable mental health and substance use disorder parity laws. The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987 1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance. 2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight. 3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale. 4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity. 5. Our AMA supports improved transparency of PBM operations, including disclosing: - Utilization information;

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		satisfaction, and should utilize findings to both modify and improve plan policies when indicated and improve practitioner performance through educational feedback. (CMS Rep. 2, A-96; Modified:CMS Rep. 6, I-00; Reaffirmed:CMS Rep. 9, A-01; Reaffirmed Res. 702, I-01; Reaffirmation A-02; Reaffirmed:CMS Rep. 4, A-12)	- Rebate and discount information; - Financial incentive information; - Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy; - Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records; - Methodology and sources utilized to determine drug classification and multiple source generic pricing; and - Percentage of sole source contracts awarded annually. 6. Our AMA encourages increased transparency in how DIR fees are determined and calculated. Integrating Physical and Behavioral Health Care H-385.915 Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the

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			same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings.
H-285.979	Managed Care Insurance Company Credentialing	The AMA: (1) supports the development and utilization by all health insurance plans and managed care organizations of both a uniform application form and a reapplication form; (2) will work with the centralized credentialing collection services established by state and county medical societies to implement the acceptance of uniform application and reapplication forms; (3) urges managed care organizations to recredential participating physicians no more frequently than every two years; (4) urges hospitals, managed care organizations and insurance companies to utilize state and county central credentialing services, where available, for purposes of credentialing plan physician applicants, and will identify all state and county central credentialing services and make this information available to all interested parties including hospital and managed care/physician credentialing committees; (5) supports state and county medical society initiatives to promulgate a uniform reappointment cycle for hospitals and managed care plans; and (6) opposes any legislative or regulatory initiative to mandate	Retain. Still relevant.

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		accreditation for CVOs by the NCQA or any other agency until a fair, equitable, reasonable and appropriately inclusive process for such accreditation exists. (Sub. Res. 703, A-94; Amended in lieu of Res. 705, I-94; Amended by Res. 716, I-96; Reaffirmed: Res. 809, I-02; Reaffirmed:CMS Rep. 4, A-12)	
H-290.975	State and Federal Medicaid Physician Advisory Bodies	Our AMA supports the creation of state Medicaid Physician Advisory Commissions that would advise states on payment policies, utilization of services, and other relevant policies impacting physicians and patients. (BOT Rep. 13, I-02; Modified:CMS Rep. 4, A-12)	Rescind. Superseded by Policy H-165.855[8], which states: Medical Care for Patients with Low Incomes H-165.855 It is the policy of our AMA that: … (8) our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects.
H-330.889	Strengthening Medicare for Current and Future Generations	1. It is the policy of our AMA that a Medicare defined contribution program should include the following: a. Enable beneficiaries to purchase coverage of their choice from among competing health insurance plans, which would be subject to appropriate regulation and oversight to ensure strong patient and physician protections. b. Preserve traditional Medicare as an option. c. Offer a wide range of plans (e.g., HMOs, PPOs, high-deductible plans paired with health savings accounts), as well as traditional Medicare. d. Require that competing private health insurance plans meet guaranteed issue and guaranteed renewability requirements, be prohibited from rescinding coverage except in cases of intentional fraud, follow uniform marketing standards, meet plan solvency requirements, and cover at least the actuarial equivalent of the benefit package provided by traditional Medicare e. Apply risk-adjustment methodologies to ensure that affordable private health insurance coverage options are available for sicker beneficiaries and those with higher	Rescind. Superseded by Policy H-330.896, which states: Strategies to Strengthen the Medicare Program H-330.896 Our AMA supports the following reforms to strengthen the Medicare program, to be implemented together or separately, and phased-in as appropriate: 1. Restructuring beneficiary cost-sharing so that patients have a single premium and deductible for all Medicare services, with means-tested subsidies and out-of-pocket spending limits that protect against catastrophic expenses. The cost-sharing structure should be developed to provide incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care. The use of preventive services should also be encouraged. Simultaneously, policymakers will need to consider modifications to Medicare supplemental

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		projected health care costs. f. Set the amount of the baseline defined contribution at the value of the government's contribution under traditional Medicare. g. Ensure that health insurance coverage is affordable for all beneficiaries by allowing for adjustments to the baseline defined contribution amount. In particular, individual defined contribution amounts should vary based on beneficiary age, income and health status. Lower income and sicker beneficiaries would receive larger defined contributions. h. Adjust baseline defined contribution amounts annually to ensure that health insurance coverage remains affordable for all beneficiaries. Annual adjustments should reflect changes in health care costs and the cost of obtaining health insurance. i. Include implementation time frames that ensure a phased-in approach. 2. Our AMA will advocate that any efforts to strengthen the Medicare program ensure that mechanisms are in place for financing graduate medical education at a level that will provide workforce stability and an adequate supply of physicians to care for all Americans. 3. Our AMA will continue to explore the effects of transitioning Medicare to a defined contribution program on cost and access to care. (CMS Rep. 5, I-12)	insurance (i.e., Medigap) benefit design standards to ensure that policies complement, rather than duplicate or undermine, Medicare's new cost-sharing structure. 2. Offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. All plans would be subject to the same fixed contribution amounts and regulatory requirements. Policies would need to be developed, and sufficient resources allocated, to ensure appropriate government standard setting and regulatory oversight of plans. 3. Restructuring age-eligibility requirements and incentives to match the Social Security schedule of benefits
H-330.890	Decoupling Social Security from Medicare	Our AMA supports abrogation of any connection between Medicare and Social Security benefits. (Res. 221, I-12)	Retain. Still relevant.
H-330.908	CMS Required Diabetic Supply Forms	Our AMA requests that CMS change its requirement so that physicians need only re-write prescriptions for glucose monitors every twelve months, instead of a six month requirement, for Medicare covered diabetic patients and make the appropriate diagnosis code sufficient for the determination of medical necessity. (Sub. Res. 102, A-00; Reaffirmation and Amended: Res. 520, A-02; Modified:CMS Rep. 4, A-12)	Retain. Still relevant.

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H-335.970	Medicare Integrity Program	Our AMA strongly urges CMS to adhere to the following principles during the implementation of the Medicare Integrity Program (MIP): (1) continue support for physician development of local medical review policy through strong Carrier Advisory Committees; (2) provide access to a Medical Director in each state; (3) provide a mechanism for close surveillance and monitoring of the performance of the MIP contractors to assure their accountability to questions and concerns raised by patients and physicians about coverage and other issues; (4) continue due process and appeals mechanisms for physicians; and (5) initiate a widespread and comprehensive effort to educate physicians about all aspects of the MIP. (CMS Rep. 4, A-97; Reaffirmed:CMS Rep. 1, A-99; Reaffirmation A-02; Reaffirmed:CMS Rep. 4, A-12)	Rescind. Policy is out-of-date. Medicare Integrity Program is no longer active.
H-383.997	Hospital-Based Physician Contracting	(1) It is the policy of the AMA that agreements between hospitals and hospital-based physicians should adhere to the following principles: (a) Physicians should have the right to negotiate and review their own portion of agreements with managed care organizations. (b) Physicians should have the right to set the parameters and acceptable terms for their contracts with managed care plans in advance of contract negotiations. (c) Physicians representing all relevant specialties should be involved in negotiating and reviewing agreements with managed care organizations when the agreements have an impact on such issues as global pricing arrangements, risks to the physician specialists, or expectations of special service from the specialty. (d) Physicians should have the opportunity to renegotiate contracts with the hospital whenever the hospital enters into an agreement with a managed care plan that materially impacts the physician unfavorably. (e) The failure of physicians to reach an agreement with managed care	Retain-in-part. The publications listed in subsection 3 are out-of-print, making the subsection out-of-date. Subsection 3 should be rescinded. (3) Our AMA encourages physicians to avail themselves of the contracting resources available through their relevant specialty societies, as well as the AMA Model Medical Services Agreement, and the Young Physician Section pamphlet entitled "Contracts: What You Need to Know," to evaluate and respond to contract proposals.

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		organizations should not constitute a breach of its agreement with the hospital, nor serve as grounds for termination. (f) Physicians should seek a provision that allows them to opt out from managed care plans that pose unacceptable professional liability risks. (g) Physicians should seek a provision to refuse to contract with, to modify contracts with, and/or to terminate contracts with managed care plans that are showing financial instability, or should seek a guarantee from the hospital that the plan will make timely payments. (h) Physicians should receive advance notice of the hospital's intent to enter into any package or global pricing arrangements involving their specialties, and have the opportunity to advise the hospital of their revenue needs for each package price. (i) Physicians should have the opportunity to request alternative dispute resolution mechanisms to resolve disputes with the hospital concerning managed care contracting. (j) If the hospital negotiates a package pricing arrangement and does not abide by the pricing recommendations of the physicians, then the physicians should be entitled to a review of the hospital's actions and to opportunities to seek additional compensation. (k) Physicians should be entitled to information regarding the level of discount being provided by the hospital and by other participating physicians. (2) Our AMA urges physicians who believe hospitals are negotiating managed care contracts on their behalf without appropriate input, and who feel coerced into signing such contracts, to contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel. (3) Our AMA encourages physicians to avail themselves of the contracting resources available through their relevant specialty societies, as well as the AMA Model Medical Services Agreement, and the Young Physician Section pamphlet entitled "Contracts:	

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		What You Need to Know," to evaluate and respond to contract proposals. (CMS Rep. 3, A-00; Reaffirmed: BOT Rep. 13, I-06; Reaffirmed: BOT Rep. 4, I-12)	
H-385.922	Payment Terminology	It is AMA policy to change the terminology used in compensating physicians from "reimbursement" to "payment." (Res. 138, A-07; Reaffirmation A-12)	Retain. Still relevant.
H-385.958	Payment for Services Not Authorized by Health Plans	Our AMA advocates that all health plan contracts contain a provision to permit the direct billing of patients for medical services for which authorization was denied by a health plan, which the rendering physician, based upon reasonable evidence, determines to be essential for the welfare of the patient and for which prior patient consent was obtained. (Sub. Res. 705, I-93; Reaffirmation A-02; Reaffirmed:CMS Rep. 4, A-12)	Retain. Still relevant.
H-385.961	Medicare Private Contracting	Our AMA will: (1) continue to pursue legal and administrative efforts to permit patients to contract privately with their physicians in appropriate circumstances; and (2) support repeal of the restrictions placed on private contracts between physicians and Medicare beneficiaries to ensure that there is no interference with Medicare beneficiaries' freedom to choose a physician to provide covered services and give priority to this goal as a legislative objective. (BOT Rep. OO, A-93; Reaffirmed: Sub. Res. 132, A-94; Appended: Res. 203, I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation I-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation A-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 5, I-12)	Rescind. Superseded by Policy D-380-997, which states: 1. It is the policy of the AMA: (a) that any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services; (b) to pursue appropriate legislative and legal means to permanently preserve that patient's basic right to privately contract with physicians for wanted or needed health care services; (c) to continue to expeditiously pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the physician/patient relationship; and (d) to seek immediately suitable cases to reverse the limitations on patient and physician rights to contract privately that have

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			been imposed by CMS or the private health insurance industry. 2. Our AMA strongly urge CMS to clarify the technical and statutory ambiguities of the private contracting language contained in Section 4507 of the Balanced Budget Act of 1997. 3. Our AMA reaffirms its position in favor of a pluralistic health care delivery system to include fee-for-service medicine, and will lobby for the elimination of any restrictions and physician penalties for provision of fee-for-service medicine by a physician to a consenting patient, including patients covered under Medicare
H-385.984	Fee for Services When Fulfilling Third Party Payer Requirements	The AMA believes that the attending physician should perform without charge simple administrative services required to enable the patient to receive his benefits. When more complex administrative services are required by third parties, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage, it is the right of the physician to be recompensed for his incurred administrative costs. (CMS Rep. J, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 3, I-12)	Rescind. Superseded by Policy H-285.943, which states that the AMA (1) opposes managed care contract provisions that prohibit physician payment for the provision of administrative services; (2) encourages physicians entering into: (a) capitated arrangements with managed care plans to seek the inclusion of a separate capitation rate (per member per month payment) for the provision of administrative services, and (b) fee-for-service arrangements with managed care plans to seek a separate case management fee or higher level of payment to account for the provision of administrative services; and (3) supports the concept of a time-based charge for administrative duties (such as phone precertification, utilization review activities, formulary review, etc.), to be assessed to the various insurers.

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H-385.985	Denial of Payment for Medical Services Based Solely on Fiscal Considerations	Our AMA: (1) affirms that medical judgment as to the need for an assistant in any surgical procedure, or the need to provide any form of medical care, should be made by the physician based on what is best for the health and welfare of the patient and not on fiscal restraints or considerations; and (2) opposes any law, rule or regulation, or any decision by a third party carrier which denies payment for medical services due solely to fiscal considerations and which does not have as its primary purpose the health and safety of the patient. (Res. 12, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: BOT Rep. 32, A-99; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)	Retain. Still relevant.
H-390.845	Mandatory Physician Enrollment in Medicare	Our AMA supports every physician's ability to choose not to enroll in Medicare and will seek the right of patients to collect from Medicare for covered services provided by unenrolled or disenrolled physicians. (Res. 223, I-12)	Retain. Still relevant.
H-390.846	Three-Day Payment Window Rule	Our AMA will: (1) work with the Centers for Medicare & Medicaid Services (CMS) to request a further delay in implementation of the 3-day Payment Window rule beyond the current delay of July 1, 2012; (2) thoroughly investigate all legislative and regulatory actions taken by Congress and CMS associated with the 3-Day Payment Window during this delay and determine whether additional legislative and/or regulatory actions are warranted to include overturning the current rule; and (3) work with other appropriate stakeholders to continue seeking a delay or modification of the three-day payment window rule; encourage CMS to clarify to whom and how this rule applies; and communicate the specifics about this rule to the physician community. (Res. 226, A-12)	Rescind. This policy was accomplished in 2012 and is out-of-date.
H-390.874	Repayment of Medicare Overpayments Made in Error	1. The AMA will request CMS to require Medicare carriers to be financially responsible for repayment to CMS of any overpayments made by the carrier to physicians where physicians could not reasonably be aware that the payments were overpayments or in	Rescind. Subsection 1 is superseded by Policy H-390.880, and Subsection 2 is out-of-date. Interest Rates Charged and Paid by CMS H-390.880

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		error and where the physicians relied on calculations by the carrier. 2. Our AMA will: (A) communicate to the US Department of Health and Human Services (DHHS) its strong objection to the proposed plan to collect overpayment of Medicare services within 60 days of discovery, regardless of how this might affect the cash flow and the solvency of a medical practice; and (B) express to DHHS its strong objection to the proposed rule which would require practices or auditors to report any overpayments that were discovered within ten years of the date the funds were received instead of the current six-year requirement, due to the burden this would place on physicians' practices, which in essence is another unfunded mandate. (Res. 224, I-93; Reaffirmed:CMS Rep. 10, A-03; Appended: Res. 212, A-12)	1. (A) Our AMA will (1) determine if the recent interest rate changes implemented by CMS comply with current Medicare laws; (2) seek to ensure that CMS's interest charges do not exceed legal limits; and (3) work with CMS to ensure parity in interest rates assessed against physicians by CMS and interest rates paid to physicians by CMS. (B) If an agreement cannot be reached with CMS, the AMA will seek legislation to correct this situation. 2. Our AMA supports amending federal Medicare law to require that interest on both overpayments and underpayments to providers attaches upon notice of the error to the appropriate party in either instance.
H-40.969	CHAMPUS Payment	(1) The AMA urges the Department of Defense to raise to at least Medicare levels those CHAMPUS maximum allowable charges (CMACs) that are presently below Medicare allowable charges. (2) The AMA urges the Department of Defense to eliminate price controls and encourage competition under TRICARE through true pluralism in the health plan choices available to beneficiaries, consistent with AMA Policy H-165.890, which proposes advocating transformation of the current Medicare program through an invigorated marketplace. Consistent with Policy H-165.890, this approach should use a defined contribution by CHAMPUS, regardless of the health plan chosen. (3) Until TRICARE introduces a contracting approach that increases competition and sets physician payments through the marketplace, the AMA urges the Department of Defense to assure that all TRICARE programs pay physicians at a minimum of CMAC levels, consistent with Policy H-40.972. (BOT Rep. 1, I-96; Reaffirmed:CMS Rep. 8,	Rescind. Superseded by Policy D-40.991, which states: Our AMA: 1. Encourages state medical associations and national medical specialty societies to educate their members regarding TRICARE, including changes and improvements made to its operation, contracting processes and mechanisms for dispute resolution. 2. Encourages the TRICARE Management Activity to improve its physician education programs, including those focused on non-network physicians, to facilitate increased civilian physician participation and improved coordination of care and transfer of clinical information in the program. 3. Encourages the TRICARE Management Activity and its contractors to continue and strengthen their efforts to

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		A-06; Reaffirmed:CMS Rep. 2, I-08; Reaffirmation A-12)	recruit and retain mental health and addiction service providers in TRICARE networks, which should include providing adequate reimbursement for mental health and addiction services. 4. Strongly urges the TRICARE Management Activity to implement significant increases in physician payment rates to ensure all TRICARE beneficiaries, including service members and their families, have adequate access to and choice of physicians. 5. Strongly urges the TRICARE Management Activity to alter its payment formula for vaccines for routine childhood immunizations, so that payments for vaccines reflect the published CDC retail list price for vaccines. 6. Continues to encourage state medical associations and national medical specialty societies to respond to requests for information regarding potential TRICARE access issues so that this information can be shared with TRICARE representatives as they develop their annual access survey. 7. Continues to advocate for changes in TRICARE payment policies that will remove barriers to physician participation and support new, more effective care delivery models, including: (a) establishing a process to allow midlevel providers to receive 100 percent of the TRICARE allowable cost for services rendered while practicing as part of a physician-led health care team, consistent with state law; and (b) paying for

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			transitional care management services, including payment of copays for services provided to TRICARE for Life beneficiaries receiving primary coverage through Medicare. 8. Continues to advocate for improvements in the communication and implementation of TRICARE coverage policies to ensure continued patient access to necessary services, including: (a) consistently approving full payment for services rendered for the diagnosis and treatment of common mental health conditions, regardless of the specialty of the treating physician; and (b) clarifying policies with respect to coverage for age appropriate doses of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices.
H-440.903	Public Health Care Benefits	Our AMA actively lobby the federal and state governments to restore and maintain funding for public health care benefits for all legal immigrants. (Res. 219, A-98; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, A-12)	Retain-in-part. Update language from "legal" to "lawfully present," as follows: Our AMA actively lobby the federal and state governments to restore and maintain funding for public health care benefits for all ~~legal~~ lawfully present immigrants.
H-480.961	Teleconsultations and Medicare Reimbursement	Our AMA demands that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various "fee splitting" or "fee sharing" reimbursement schemes. (Res. 144, A-93; Reaffirmed:CMS Rep. 10, A-03; Reaffirmation A-07; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed in lieu of Res. 806, I-12)	Rescind. Superseded by Policies H-480.937 and H-480.946. Addressing Equity in Telehealth H-480.937 Our AMA: (1) recognizes access to broadband internet as a social determinant of health; (2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for

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			historically marginalized and minoritized populations; (3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations; (4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities; (5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth; (6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically

Policy #	Title	Text	Recommendation
			marginalized, minoritized and underserved populations; (7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth; (8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians; and (9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. Coverage of and Payment for Telemedicine H-480.946 1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles: a) A valid patient-physician relationship must be established before the provision of telemedicine services, through: - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or - Meeting standards of establishing a patient-physician relationship

Policy #	Title	Text	Recommendation
			included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology. Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services. b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services. c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board. d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services. e) The delivery of telemedicine services must be consistent with state scope of practice laws. f) Patients receiving telemedicine services must have access to the licensure and board certification

Policy #	Title	Text	Recommendation
			qualifications of the health care practitioners who are providing the care in advance of their visit. g) The standards and scope of telemedicine services should be consistent with related in-person services. h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes. i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine. j) The patient's medical history must be collected as part of the provision of any telemedicine service. k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient. l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record. m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

Policy #	Title	Text	Recommendation
			2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information. 3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine. 4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine. 5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models. 6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service. 7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-22

Subject: Prospective Payment Model Best Practices for Independent Private Practice (Resolution 122-J-21)

Presented by: Asa C. Lockhart, MD, MBA, Chair

Referred to: Reference Committee G

At the June 2021 Special Meeting, the House of Delegates referred Resolution 122, "Developing Best Practices for Prospective Payment Models," which was sponsored by the Integrated Physician Practice Section. Resolution 122-J-21 asked the American Medical Association (AMA) to "study and identify best practices for financially viable models for prospective payment health insurance, including but not limited to appropriately attributing and allocating patients to physicians, elucidating best practices for systems with multiple payment contracts, and determining benchmarks for adequate infrastructure, capital investment, and models that accommodate variations in existing systems and practices" and to "use recommendations generated by its research to actively advocate for expanded use and access to prospective payment models."

Testimony was generally supportive of the intent of Resolution 122-J-21. Testimony also cited longstanding AMA support for pluralism and noted that payment systems are complex and may affect various medical specialties differently. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report acknowledges a vast wealth of AMA policy outlining best practices for prospective payment models. In addition, physicians practicing in large integrated systems have those systems to provide guidance. Accordingly, while addressing practices that affect large integrated systems, the Council also focuses this report on the development of principles to guide physicians in non-integrated (independent) private practice wishing to enter into contractual agreements with other physician practices to form clinically integrated networks (CINs) for the purposes of engaging in prospective payment models.

BACKGROUND

The move to value-based payment by both public and private payers has been advancing for more than a decade, driven by concerns with quality outcomes and accelerating health care costs. The AMA, in two qualitative studies conducted with the RAND Corporation, has examined the effects of these new payment models, often referred to as "Alternative Payment Models" or APMs, on physician practices and found that as recently as 2018, there remained significant barriers to the adoption of such models.[1] These barriers include:

- Lack of timely/accessible data for practices;
- Operational errors in payment models;
- Challenges related to interactions between payment models;
- Accelerated pace of change in payment models;
- Sudden or unexpected discontinuations of APMs; and
- Increasing complexity of payment models.

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With the onset of the COVID-19 pandemic in 2020, adoption of value-based payment models slowed as the health care system managed the intense pressure of providing critical care for millions of severely ill patients. Most health care offices were forced to limit visits, many patients avoided and delayed seeking treatment, and many hospitals and outpatient facilities greatly reduced or canceled elective surgeries.[2] While all health care facilities and practices experienced serious financial disruption and many were forced to furlough or eliminate staff, suggestions have arisen that primary care practices who were in prospective payment models, such as per-member-per-month (PMPM), were able to manage the financial disruption more readily than those who were mostly dependent on fee-for-service (FFS) payments.[3]

Appropriately funded prospective payment models offer one solution to provide potential stability and predictability of payment for some practices when demand for services decreases. Such models include capitation, global payments, PMPM payments and can provide physicians with more predictable financial resources to conduct care coordination activities that can improve outcomes, decrease more costly visits to hospitals, and reduce readmissions. Funding for these models should be sufficient to address the social determinants of health (SDOH) for the target population.

Prospective payment models can take many forms. They can coexist with shared savings models and can be found among APMs. Numerous prospective payment models are being implemented currently, while others have been cancelled. In the Medicare program, Medicare Advantage plans receive capitation payments, and some pay their network physicians on a capitated basis, although many still pay on a per-service basis. For a listing of models in the traditional Medicare program, please visit the Centers for Medicare & Medicaid Services (CMS) sites for approved Alternative Payment Models and the CMS Center for Medicare & Medicaid Innovation (CMMI).[5,6]

CONSIDERATIONS FOR PROSPECTIVE PAYMENT MODELS

Consistent with robust AMA policy, the AMA has been highly engaged with CMS, CMMI, and commercial health plans regarding physician concerns that payment reform models should enable rather than impede the provision of appropriate and necessary care. Longstanding AMA Policy H-385.926 supports the freedom of physicians to choose their method of earning a living, a concern raised during testimony on Resolution 122-J-21. For physicians exploring the opportunities to engage in prospective payment models, the following factors should be considered.

Attribution

Current retrospective statistical attribution methodologies often fail to accurately assign to physicians the patients they cared for and the services they delivered. The purpose of attribution and corresponding performance measures should be to ensure that physicians are responsible only for the costs they can control and not for costs they cannot control. Physicians in private practice can be particularly impacted when inpatient and specialty care are inappropriately attributed to them. These are costs that such physicians might not be able to control.

Attribution methods that rely solely on retrospective claims are problematic. Physicians providing telehealth services and fewer in-person visits need to use an additional payment code (i.e., modifier 95) to have the patient attributed to them. Various attribution methods could provide mixed results for physicians regarding who is responsible for delivering efficient care. Any delay in providing physicians with lists of attributed patients in real-time stifles timely care coordination. Additionally, errors can occur where patients rarely or never seen by a physician are attributed to them, or conversely, patients to whom they have provided extensive services to are attributed to someone else. Adjudicating these attribution lists can be extremely time consuming, particularly

for private practices with limited staffing and resources. Furthermore, such inaccuracies may negatively affect a physician's payment rate especially if the corresponding quality and cost of care data associated with these patients are adverse.

Performance Targets

It is a priority that performance targets are clinically meaningful and parsimonious for physicians, including privately practicing physicians. Performance targets must be logically relevant for each specialty and evidence-based. Unachievable and irrelevant performance targets may discourage physicians from participating in evolving payment models and undermine the goals of value-based payment.

Risk Adjustment

The resources needed to achieve appropriate patient outcomes during an episode of care depend heavily on the individual needs of each patient as well as their ability to access care and properly adhere to prescribed treatment plans. Many risk adjustment methods only explain a small amount of variation, and typically focus on variation in spending, not on patient factors. Risk adjustment generally relies on historical claims data, so it may not account for significant changes in the patient's health status that affect their current needs for services. Further exacerbating data deficiencies is that most risk adjustment systems give little or no consideration to the factors other than health status that can affect patient needs, such as functional limitations, access to health care services, and other SDOH.

An additional concern is that most risk adjustment methods do not adequately account for socio-demographic factors, such as community supports, on the cost and outcomes of care. Flawed risk adjustment methods have the unwanted effect of inappropriately penalizing the physicians and health systems caring for sicker patients and individuals with socio-demographic challenges while rewarding those who do not care for these patients. As an unintended consequence, it may be harder for higher-need patients to access care and for physicians caring for these patients to maintain a sustainable practice.

Data and Health Information Technology

Costly health information technology (IT) continues to be one of the greatest drags on efficiency and satisfaction in the practice of medicine and a significant barrier to the development and implementation of care delivery and payment reform. Independently practicing physicians may lack IT systems sufficient to engage in a prospective payment model. Alternatively, any practice with a robust IT system still requires reliable data to reach their potential. Innovative payment models depend on access to high quality, real-time actionable data at the point of care. Physicians' ability to participate in new payment models often hinge on health IT systems that support and streamline participation. Without the appropriate tools, physicians will continue to struggle to track the metrics necessary to inform and improve care delivery. Physicians must have the guidance and technical assistance to meaningfully participate in prospective payment models and other APMs. Barriers to interoperability and access to patient data must be overcome if APMs are to enjoy widespread acceptance and participation.

Telehealth

The COVID-19 pandemic accelerated uptake of telehealth. In 2020, physicians and health systems quickly deployed and expanded telehealth technology to diagnose, treat, and advise millions of patients. Before the pandemic, telehealth accounted for less than one percent of Medicare expenditures for physician services. It rose to as high as 16 percent during the spring of 2020 and then stabilized at between four and six percent for the remainder of that year. Medicare spent $4.1 billion on physician telehealth services in all of 2020 and $2 billion in the first six months of 2021.[4]

The adoption of telehealth illustrates how payment policy can serve as a catalyst to reform. The rapid expansion of telehealth services in response to the COVID-19 pandemic was possible after long-standing payment barriers were removed. Telehealth payment enables physicians to provide needed services to homebound and remote patients, as well as minimizing patient time away from work and other responsibilities.

Increasingly, physicians and patients deploy telehealth services. AMA Physician Practice Benchmark Survey data show that, in 2020, 79 percent of physicians were in practices that used any type of telehealth and 70 percent were in one that used video conferencing with patients. Still, some patients lack the access to technology such as broadband, which is necessary to deploy advanced telehealth technologies and many lack the skills needed to receive care via telehealth. Similarly, many physicians and health systems lack the capital needed to purchase necessary services and equipment to provide secure telehealth services. Ultimately, these barriers disproportionately impact physicians in rural areas, safety net providers, and patients from historically marginalized and minoritized communities.

AMA POLICY

The AMA has a wealth of policy directly related to prospective payment models, including policy addressing persistent concerns with value-based payment and APMs (Policies D-385.963, H-385.913, H-385.908, and H-390.849), specific physician-led payment reforms (Policies D-390.953, H-390.844, H-450.931, H-450.961, and D-35.985), the importance of physician involvement in health IT (Policies D-478.972, D-478.995, D-478.996, H-450.933, and H-478.984), telehealth (Policies D-480.963, H-478.980, H-478.996, D-480.965, H-480.946, H-390.889, D-480.969, H-450.941, and Policy D-155.987), and improving risk adjustment (Policy H-385.907 and H-285.957).

In addition, Policies H-165.844 and H-385.926 reiterate the AMA's long-standing commitment to pluralism and physician freedom of enterprise.

AMA ADVOCACY

The AMA continues to carefully examine APMs that are developed by CMS and provides feedback to the agency regarding needed modifications to enable physicians to deliver high-quality care. The AMA has also expressed concern if APMs could impose unreasonable requirements on physicians or require them to shoulder excessive financial risk. When the AMA identifies problems with an APM, it advocates for appropriate changes which have resulted in improvements in some current APMs. Examples of AMA advocacy to improve Medicare APMs include:

- The AMA has testified to Congress about the importance of having physicians involved in designing APMs in order for the APMs to be successful.

- AMA regularly submits comments to CMS identifying problems with the APMs that CMS has developed, including recommendations for improvements.
- AMA submits comments to CMS each year describing ways to improve the overall regulations that define what qualifies as an APM and what physicians must do to meet the requirements of Medicare's Quality Payment Program.
- AMA has worked closely with national medical specialty societies and other national organizations, as well as state medical associations, to develop and recommend changes in public policy on APMs.

CMMI recently published its "strategy refresh," describing new objectives for CMMI based on its experience with APMs during its first 10 years.[7] A number of the policies outlined in the CMMI strategy are encouraging as they would implement recommendations made to CMMI leadership in a May 2021 letter from the AMA and many national specialty societies, as well as in several meetings.[8] These include CMMI plans to:

- Make APM parameters, requirements, and other critical details as transparent and easily understandable as possible for participants;
- Reduce administrative burdens from APM participation requirements;
- Make available and increase uptake of actionable data, learning collaboratives, and payment and regulatory flexibilities to participants, especially those treating the underserved;
- Improve testing and analysis of benchmarks and risk adjustment methods;
- Deepen and sustain outreach and solicitation of input from patient and physician groups;
- Explore model tests for specialty care payment models; and
- Identify ways to align or integrate episode payment models with accountable care models.

AMA Physician Practice Benchmark Survey

The AMA's Physician Practice Benchmark Survey has been conducted on a biennial basis starting in 2012. The 6th iteration of this nationally representative survey is planned for fall 2022. A primary focus of the survey is physician practice characteristics including employment status (whether a physician is an employee, an owner/partner, or an independent contractor), practice type (e.g., solo practice, single specialty practice, or multi-specialty practice), practice ownership (e.g., physician-owned or hospital/health system-owned), practice size (measured by number of physicians), and use of non-physician providers. A second focus of the survey is the payment methods in place between practices and payers. Methods asked about include FFS, pay-for-performance, bundled payments, shared savings, and capitation. Reports based on these topics are available on the AMA website.[9] Relevant to Resolution 122-J-21, in 2020, an average of 6 percent of practice revenue was paid through capitation.

Professional Satisfaction and Practice Sustainability

The AMA's Professional Satisfaction and Practice Sustainability (PS2) unit continues to support effective development and implementation of sustainable physician payment models through research, development of tools and resources, and support of the spread of effective models through learning collaboratives and engagement with commercial health plans and large employers. An enhanced focus on sustainable physician-owned practices has been launched through its Private Practice Initiative, which offers resources such as its new series on Payor Contracting and forming Clinically Integrated Networks.[10,11]

DISCUSSION

The AMA has robust policy articulating best practices and principles for APMs, including prospective payment models (see Appendix). These policies guide continued AMA advocacy for the development and implementation of such models, including the necessary resources to make them successful. The Council recommends reaffirming policies that support a commitment to pluralism and the ability of physicians to choose their method of earning a living. The Council also recommends reaffirming policies that address the areas of concern highlighted by Resolution 122-J-21, as detailed in the Appendix regarding attribution, risk adjustment, physician involvement in contract negotiations, access to data reports, infrastructure, and capital investment (including for the delivery of telehealth), technical support and payment updates.

Consistent with Resolution 122-J-21, the Council recommends new policy to support increased inclusion of elements of prospective payment models for independent practices in the development of payment reform. The Council also recommends new principles to address the unique needs of independently practicing physicians wishing to address the challenges of contracting for prospective payments with other independent physicians. Principles should include the following:

- Compensation should incentivize the interdependence of the physician group members and foster collegiality between specialties.
- Attribution, performance targets and risk adjustment are likely to benefit from clinical data in addition to claims data.
- Any quality metrics should be clinically meaningful and developed with physician input.
- Models should strive to address community social determinants of health, with attention to patient attribution and contracted payers.
- Physicians should be leaders in their model's governance, which must be autonomous to monitor performance targets and price transparency, and to ensure that socio-demographic factors impacting overall patient health are addressed. In addition, model governance should address the purchase and leverage of high-quality health IT for better patient care and leverage group purchasing organizations to lower cost of telehealth technology.

The Council encourages the AMA and other entities, such as state and specialty medical societies, to continue to provide the guidance and infrastructure needed to allow physicians to join with other physicians.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 122-J-21, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the consideration of prospective payment elements in the development of payment and delivery reform that are consistent with AMA principles. (New HOD Policy)

2. That our AMA support the following principles to support physicians who choose to participate in prospective payment models:
    a. The AMA, state medical associations, and national medical specialty societies should be encouraged to continue to provide guidance and support infrastructure that allow independent physicians to join with other physicians in clinically integrated networks, independent of any hospital system.

b. Prospective payment model compensation should incentivize specialty and primary care collegiality among independently practicing physicians.
c. Prospective payment models should take into consideration clinical data, where appropriate, in addition to claims data.
d. Governance within the model must be physician-led and autonomous.
e. Physician practices should be encouraged to work with field advisors on patient attributions and a balanced mix of payers.
f. Quality metrics used in the model should be clinically meaningful and developed with physician input.
g. Administrative burdens, such as those related to prior authorization, should be reduced for participating physicians.(New HOD Policy)

3. That our AMA reaffirm Policies H-165.844 and H-385.926, which support pluralism and the freedom of physician enterprise. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-385.907, which supports fair and accurate risk adjustment. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policies H-385.913, D-478.972, D-478.995, H-478.984, H-478.980, D-480.965, H-480.946, D-480.969 and H-285.957, which collectively address the concerns raised in Resolution 122-I-21. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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Council on Medical Service Report 2-A-22
Prospective Payment Model Best Practices for Independent Private Practice
Policy Appendix

Policy H-165.844 Educating the American People About Health System Reform
Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system. (Res. 717, I-07 Reaffirmation A-09 Reaffirmed: CMS Rep. 01, A-19)

Policy H-285.957 Use of Risk-Adjustment Mechanisms for Physician Compensation Under Capitation Contracts
The AMA will work with interested medical organizations in urging state Medicaid programs and other third party payers to assure the inclusion of risk adjustment mechanisms in capitation rates paid to physicians providing care to chronically ill children and adults enrolled in managed care plans. (Sub. Res. 128, A-96 Reaffirmed: CMS Rep. 8, A-06 Modified: CMS Rep. 01, A-16)

Policy H-385.907 Improving Risk Adjustment in Alternative Payment Models
Our AMA supports:
(1) risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications;
(2) risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer's cost;
(3) risk adjustment systems that use risk corridors that use fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer's cost;
(4) risk adjustment systems that use fair and accurate payments for external price changes beyond the physician's control; (5) accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence; and
(6) risk adjustment mechanisms that allow for flexibility to account for changes in science and practice as to not discourage or punish early adopters of effective therapy. (CMS Rep. 03, I-19)

Policy H-385.913 Physician-Focused Alternative Payment Models
1. Our AMA recognizes that the physician is best suited to assume a leadership role in transitioning to alternative payment models (APMs).
2. Our AMA supports that the following goals be pursued as part of an APM:
A. Be designed by physicians or with significant input and involvement by physicians;
B. Provide flexibility to physicians to deliver the care their patients need;
C. Promote physician-led, team-based care coordination that is collaborative and patient-centered;
D. Reduce burdens of Health Information Technology (HIT) usage in medical practice;
E. Provide adequate and predictable resources to support the services physician practices need to deliver to patients, and should include mechanisms for regularly updating the amounts of payment to ensure they continue to be adequate to support the costs of high-quality care for patients;
F. Limit physician accountability to aspects of spending and quality that they can reasonably influence;
G. Avoid placing physician practices at substantial financial risk;
H. Minimize administrative burdens on physician practices; and
I. Be feasible for physicians in every specialty and for practices of every size to participate in.

3. Our AMA supports the following guidelines to help medical societies and other physician organizations identify and develop feasible APMs for their members:
A. Identify leading health conditions or procedures in a practice;
B. Identify barriers in the current payment system;
C. Identify potential solutions to reduce spending through improved care;
D. Understand the patient population, including non-clinical factors, to identify patients suitable for participation in an APM;
E. Define services to be covered under an APM;
F. Identify measures of the aspects of utilization and spending that physicians can control;
G. Develop a core set of outcomes-focused quality measures including mechanisms for regularly updating quality measures;
H. Obtain and analyze data needed to demonstrate financial feasibility for practice, payers, and patients;
I. Identify mechanisms for ensuring adequacy of payment; and
J. Seek support from other physicians, physician groups, and patients.
4. Our AMA encourages CMS and private payers to support the following types of technical assistance for physician practices that are working to implement successful APMs:
A. Assistance in designing and utilizing a team approach that divides responsibilities among physicians and supporting allied health professionals;
B. Assistance in obtaining the data and analysis needed to monitor and improve performance;
C. Assistance in forming partnerships and alliances to achieve economies of scale and to share tools, resources, and data without the need to consolidate organizationally;
D. Assistance in obtaining the financial resources needed to transition to new payment models and to manage fluctuations in revenues and costs; and
E. Guidance for physician organizations in obtaining deemed status for APMs that are replicable, and in implementing APMs that have deemed status in other practice settings and specialties.
5. Our AMA will continue to work with appropriate organizations, including national medical specialty societies and state medical associations, to educate physicians on alternative payment models and provide educational resources and support that encourage the physician-led development and implementation of alternative payment models. (CMS Rep. 09, A-16 Reaffirmed: CMS Rep. 10, A-17 Reaffirmed: CMS Rep. 10, A-19 Reaffirmed: BOT Rep. 13, I-20)

Policy H-385.926 Physician Choice of Practice
Our AMA: (1) encourages the growth and development of the physician/patient contract;
(2) supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.);
(3) supports the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers. (This right may be limited by contractual agreement.) An accompanying responsibility of the physician is to provide to the patient adequate fee information prior to the provision of the service. In circumstances where it is not feasible to provide fee information ahead of time, fairness in application of market-based principles demands such fees be subject, upon complaint, to expedited professional review as to appropriateness; and
(4) encourages physicians when setting their fees to take into consideration the out-of-pocket expenses paid by patients under a system of individually selected and owned health insurance. (BOT Rep. QQ, I-91 Reaffirmed: BOT Rep. TT, I-92 Reaffirmed: Ref. Cmte. A, A-93 Reaffirmed: BOT Rep. UU, A-93 Reaffirmed: CMS Rep. G, A-93 Reaffirmed: CMS Rep. E, A-93 Reaffirmed: Sub. Res. 701, A-93 Reaffirmation A-93 Reaffirmed: BOT Rep. 25, I-93 Reaffirmed: CMS Rep. 5, I-93 Reaffirmed: CMS Rep. 10, I-93 Reaffirmed: BOT Rep. 40, I-93 Reaffirmed: Sub. Res. 107,

I-93 Res. 124, I-93 Reaffirmed: Sub. Res. 127, A-94 Reaffirmed: BOT Rep. 46, A-94 Reaffirmed: Sub. Res. 132, A-94 Reaffirmed: BOT Rep. 16, I-94 Reaffirmed: CMS Rep. 8, A-95 Reaffirmed: Sub. Res. 109, A-95 Reaffirmed: Sub. Res. 125, A-95 Reaffirmed: Sub. Res. 109, I-95 Reaffirmation A-96 Reaffirmation I-96 Reaffirmation A-97 Reaffirmation I-98 Reaffirmation A-99 Appended by Res. 127, A-98 Reaffirmed: CMS Rep. 6, A-99 Reaffirmation A-00 Reaffirmation A-00 Sub. Res. 116, I-00 Reaffirmation & Reaffirmed: Res. 217, A-01 Reaffirmation A-04 Consolidated and Renumbered: CMS Rep. 7, I-05 Reaffirmation A-07 Reaffirmation A09 Reaffirmed: CMS Rep. 3, I-09 Reaffirmed in lieu of Res. 127, A-10 Reaffirmation I-13 Reaffirmation A-15 Reaffirmed: CMS Rep. 5, I-15 Reaffirmed: CMS Rep. 09, A-16 Reaffirmed: CMS Rep. 07, A-17 Reaffirmed: CMS Rep. 6, A-21)

Policy D-478.972 EHR Interoperability
Our AMA:
(1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System;
(2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;
(3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges;
(4) will continue efforts to promote interoperability of EHRs and clinical registries;
(5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;
(6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;
(7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;
(8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and
(9) will review and advocate for the implementation of appropriate recommendations from the "Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care," a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services. (Sub. Res. 212, I-15 Reaffirmed: BOT Rep. 03, I-16 Reaffirmed: Res. 221, I-16 Reaffirmed in lieu of: Res. 243, A-17 Reaffirmed: CMS Rep. 10, A-17 Appended: BOT Rep. 45, A-18 Reaffirmed: BOT Rep. 19, A-18 Appended: Res. 202, A-18 Appended: Res. 226, I-18 Reaffirmation: A-19 Reaffirmed: CMS Rep. 7, I-20)

Policy H-478.980 Increasing Access to Broadband Internet to Reduce Health Disparities
Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. (Res. 208, I-18 Reaffirmed: CMS Rep. 7, A-21)

Policy H-478.984 Prohibition of Clinical Data Blocking
Our AMA will advocate for the adoption of federal and state legislation and regulations to prohibit health care organizations and networks from blocking the electronic availability of clinical data to non-affiliated physicians who participate in the care of shared patients, thereby interfering with the provision of optimal, safe and timely care. (Res. 222, I-16 Reaffirmed: CMS Rep. 10, A-17)

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians. (Res. 730, I-04 Reaffirmed in lieu of Res. 818, I-07 Reaffirmed in lieu of Res. 726, A-08 Reaffirmation A-10 Reaffirmed: BOT Rep. 16, A-11 Modified: BOT Rep. 16, A-11 Modified: BOT Rep. 17, A-12 Reaffirmed in lieu of Res. 714, A-12 Reaffirmed in lieu of Res. 715, A-12 Reaffirmed: BOT Rep. 24, A-13 Reaffirmed in lieu of Res. 724, A-13 Appended: Res. 720, A-13 Appended: Sub. Res. 721, A-13 Reaffirmed: CMS Rep. 4, I-13 Reaffirmation I-13 Appended: BOT Rep. 18, A-14 Appended: BOT Rep. 20, A-14 Reaffirmation A-14 Reaffirmed:

BOT Rep. 17, A-15 Reaffirmed in lieu of Res. 208, A-15 Reaffirmed in lieu of Res. 223, A-15 Reaffirmation I-15 Reaffirmed: CMS Rep. 07, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 227, A-17 Reaffirmed in lieu of: Res. 243, A-17 Modified: BOT Rep. 39, A-18 Reaffirmed: BOT Rep. 45, A-18 Reaffirmed: BOT Rep. 19, A-18 Reaffirmation: A-19 Reaffirmed: CMS Rep. 3, I-19)

Policy D-478.996 Information Technology Standards and Costs
1. Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.
2. Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards. (Res. 717, A-04 Reaffirmation, A-05 Appended: Sub. Res. 707, A-06 Reaffirmation A-07 Reaffirmed in lieu of Res. 818, I-07 Reaffirmed in lieu of Res. 726, A-08 Reaffirmation I-08 Reaffirmation I-09 Reaffirmation A-10 Reaffirmation I-10 Reaffirmed: Res. 205, A-11 Reaffirmed in lieu of Res. 714, A-12 Reaffirmed in lieu of Res. 715, A-12 Reaffirmed in lieu of Res. 724, A-13 Reaffirmation I-13 Reaffirmation A-14 Reaffirmed: BOT Rep. 03, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 204, I-17 Reaffirmation: I-17 Reaffirmed: BOT Rep. 45, A-18 Reaffirmed: BOT Rep. 19, A-18 Reaffirmation: A-19 Reaffirmed: CMS Rep. 7, I-20)

Policy D-480.965 Reimbursement for Telehealth
Our AMA will work with third-party payers, the Centers for Medicare and Medicaid Services, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians. (Res. 122, A-19)

Policy D-480.969 Insurance Coverage Parity for Telemedicine Service
1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.
2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies.
3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board. (Res. 233, A-16 Reaffirmed: CMS Rep. 1, I-19 Reaffirmed: CMS Rep. 7, A-21)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-22

Subject: Poverty-Level Wages and Health (Resolution 203-N-21)

Presented by: Asa C. Lockhart, MD, MBA, Chair

Referred to: Reference Committee G

At the November 2021 Special Meeting, the House of Delegates referred Resolution 203, which was sponsored by the Medical Student Section. Resolution 203-N-21 asked the American Medical Association (AMA) to support federal minimum wage regulation such that the minimum wage increases at least with inflation in order to prevent full-time workers from experiencing the adverse health effects of poverty. Testimony at the November 2021 Special Meeting regarding the resolution was mixed, with significant testimony both supporting and opposing Resolution 203. Testimony placed Resolution 203 within the context of the AMA's advocacy regarding social determinants of health (SDOH). Testimony supporting Resolution 203 explained that a living wage is essential to promoting health and equity, while testimony in opposition indicated that increasing the federal minimum wage could cause some employers to reduce their number of employees, causing some low-wage workers to become jobless and their family incomes to fall. This report studies the impacts of poverty and minimum wage policies, highlights essential AMA policy, and presents new policy recommendations.

BACKGROUND

In the United States (US), one in 10 people lives in poverty, and despite being employed with steady work, many cannot afford things they need to stay healthy. Healthy People 2030 set a goal of economic stability to "Help people earn steady incomes that allow them to meet their health needs."[1] According to Healthy People 2030, the SDOH are "conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risk."[2] The SDOH include education, housing, wealth, income, and employment, and they are impacted by larger, powerful systems that lead to discrimination, exploitation, marginalization, exclusion, and isolation.[3] The COVID-19 pandemic has created a concurrent public health and economic crisis that has exposed and exacerbated pervasive and severe access to care issues and social inequities. Not only has the pandemic disproportionally impacted minoritized and marginalized communities, but economic insecurity, housing insecurity, and food insecurity have disproportionately burdened communities of color and other underserved populations (e.g., people living in rural areas).

The large number of confounding variables makes it challenging to directly attribute changes in minimum wage policies to health outcomes, but there is widespread consensus that populations with low incomes have worse health outcomes.[4] This exacerbates health inequities because women and people of color (many of whom provide for families) are more likely to earn low wages. Black and Hispanic individuals and families specifically are disproportionately represented among minimum wage workers. In addition, studies have found that populations with high and rising income inequality are associated with lower life expectancy, higher rates of infant mortality,

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obesity, mental illness, homicide, and other measures compared to populations with a more equitable income distribution.[5] A large body of research on wage, income, and health finds that policy interventions striving to increase the incomes of low-income populations will improve both economic measures (increasing income equality and economic security) and health measures (lower mortality rates, improve overall population health status, decrease health inequity, and lower overall health care costs).[6]

Many assume that low-wage workers are predominantly teenagers earning supplementary or optional income, but this is not accurate. Approximately 88 percent of minimum wage workers in the US are over 20 years old, and the average age is 35.[7] Based on 2019 data, approximately 48 percent of the people earning at or below the federal minimum wage have some college education, nearly 67 percent are female, and approximately 45 percent work full-time.[8] Most workers are in food service occupations (55 percent), and many others work in sales and related occupations (8.5 percent) or personal care and service roles (6.6 percent). Particularly relevant to physician practices, only 2.6 percent of minimum wage workers are characterized as having a "healthcare support" occupation, with another 4.6 percent generally characterized as holding "office and administrative" occupations.[9] Approximately 28 percent of low-wage workers have children, which places many children at risk of living in poverty.[10] Researchers have estimated that there would be 2,790 fewer low-birthweight births and 518 fewer postneonatal deaths annually if all states raised the minimum wage by one dollar. It is also critical to recognize the impact of racial, ethnic, and gender inequity. Although women make up 47 percent of the workforce overall, 64 percent of workers in frontline industries are women.[11] Moreover, while women of color make up 17 percent of the workforce overall, they are 26 percent of the frontline workforce. This inequity takes on heightened significance in light of these workers' service amidst the COVID-19 pandemic.

The current federal minimum wage of $7.25 per hour translates to an annual wage of $15,080, if working 40 hours per week for all 52 weeks of the year.[12] Workers striving to support a family on the federal minimum wage qualify for federal poverty assistance. Currently, full-time work at the federal minimum wage rate is insufficient for a single parent to support even a single child above the federal poverty line, but in 1968, the federal minimum wage was sufficient to keep a family of three out of poverty. The federal minimum wage hit its peak in inflation-adjusted terms in 1968, and since then, increases have been too small to counter the decline in value due to inflation.[13] Although current low-wage workers tend to be older (offering more experience) and more educated than their 1968 counterparts, the reduced purchasing power of the federal minimum wage means that workers must work longer hours to achieve the standard of living that was considered the minimum half a century ago. The declining value of the minimum wage has been found to be the key driver of the growth of inequality between low-wage and middle-wage workers since the late 1970s. In contrast, a federal minimum wage of $15 per hour has been predicted to raise family income for 14.4 million children, or nearly one-fifth of all US children.

HISTORY AND CURRENT STATUS OF MINUMUM WAGE

The Fair Labor Standards Act (FLSA) was enacted in 1938 and is the federal law that establishes the minimum hourly wage that must be paid to all covered workers.[14] One of the goals of the FLSA and, specifically, the minimum wage, is to "correct and as rapidly as practicable to eliminate" labor conditions "detrimental to the maintenance of the minimum standard of living for health, efficiency, and general well-being of workers."[15] However, determining what a "minimum standard of living" is, and what dollar amount is needed to support that, is a policy choice, and one that has been subject to voluminous debate. Moreover, the minimum wage is only one of many variables that influence a standard of living. The minimum wage rate has been raised 22 times, most recently in 2007 (P.L. 110-28), which increased the minimum wage to its current level of

$7.25 per hour.[16] The FLSA was intended to both protect workers and stimulate the economy, and it covers approximately 139 million workers, or 85 percent of all wage and salary workers. Under the FLSA, if states enact minimum wage, overtime, or child labor laws that are more protective of employees than the FLSA, the state law applies. As of this writing, 30 states and the District of Columbia have minimum wage laws that set the minimum wage above the federal minimum. Two states have laws that would set minimum wages below the federal rate, and five states have no minimum wage requirement. The remaining 13 states have minimum wage rates equal to the federal rate.[17] Localities (cities and counties) can also choose to establish higher minimum wages. As of this writing, 45 localities have adopted minimum wages above their state minimum wage.[18] Accordingly, the federal minimum wage serves as the wage floor for approximately 39 percent of the labor force.[19] However, the number of hourly paid workers who are earning the federal minimum wage is relatively small and decreasing in recent years (down from 1.9 percent in 2019 to 1.5 percent in 2020).[20] In 2020, 1.1 million workers earned the federal minimum wage.[21]

Given the varying mechanisms that states may have in place to adjust their minimum wage, in any year, the number of states with minimum wage rates that exceed the federal minimum can vary.[22] Generally, a legislature can adjust minimum wage in one of two ways.[23] First, a legislature may choose specific dates by which a minimum wage will increase by a specific amount. Future legislative action is then needed to subsequently increase the minimum wage. This is the approach that the federal government took with P.L. 110-28, which raised the minimum wage from $5.15 per hour in 2007 to $7.25 per hour in 2009 through three phases. Twelve of the 30 states and District of Columbia that have minimum wage rates above the federal rate follow this approach, as well. When a minimum wage is set to a specific fixed amount, inflation will cause its value to erode over time. Accordingly, as the sponsors of Resolution 203-N-21 suggest, several states have taken a second approach to minimum wage, striving to maintain the value of the minimum wage over time by linking their minimum wage to some measure of inflation. Critically, though, choosing a measure of inflation and a point at which to begin indexing minimum wage to inflation is complex, with dramatically varying results. Of the 18 states and the District of Columbia that currently or are scheduled to index their state minimum wages to inflation, six different measures of inflation have been chosen. In addition to selecting an index, policy proposals to link a minimum wage to inflation must also consider the initial value (starting point for indexation), limits to the changes, triggers for change, and periodicity of change.[24] To illustrate the importance of these detailed decisions, if the federal minimum wage had been indexed to the Consumer Price Index for All Urban Consumers (CPI-U) at the time of its enactment in 1938, when minimum wage was $0.25 per hour, the federal minimum wage would have been $4.23 per hour in 2016. In contrast, if the federal minimum wage were indexed to the CPI-U in 1968 when the rate was $1.60 per hour, it would have been $10.98 per hour in 2016. Congress has considered indexing the federal minimum wage several times but has not chosen to do so.[25] Indexation is used, however, for some federal programs, such as Social Security and Supplemental Nutrition Assistance (SNAP) benefits and in other federal wage regulations, such as the minimum wage for employees on certain federal contracts.

There have been several recent initiatives aimed at increasing the federal minimum wage. In July 2019, the House passed H.R. 582 which would increase the federal minimum wage to $15 per hour by 2025, index the minimum wage to changes in the median hourly wage, and phase out subminimum wages for some individuals currently exempt from the minimum wage.[26] In January 2021, the Raise the Wage Act of 2021 (H.R. 603) was introduced, which would incrementally raise the federal minimum wage to $15 per hour by 2025.[27] In April 2021, President Biden issued an executive order that will require federal contractors to pay a $15 per hour minimum wage for workers who are working on federal contracts.[28]

Increasing the federal minimum wage is popular among Americans – in a recent study, 80 percent of those polled believed that $7.25 per hour is too low.[29] According to the Pew Research Center, 62 percent of Americans support raising the federal minimum wage to $15 per hour.[30] Large employers including Amazon, Target, and Costco have voluntarily raised their minimum wages,[31] and a growing number of small and medium sized businesses have been committing to incrementally raising wages to $15 per hour.[32] However, Amazon is a critical example of how increased wages alone may not always translate to improvements in health or quality of life for employees. Specifically, a recent study found that Amazon warehouse workers were not only injured more often than non-Amazon warehouse workers, they were also injured more severely, and they took longer to recover than others in the warehouse industry.[33]

POLITICAL AND ECONOMIC DEBATE

Although the effects of the minimum wage have been well-studied, resulting in hundreds of academic and non-academic publications, there is no consensus on the causal relationship between changes in minimum wage and other economic outcomes.[34] The question, "Does a minimum wage cause unemployment?" has been described as, "one of the most studied questions in all of economics since at least 1912, when Massachusetts became the first state to create a minimum wage."[35] Illustrating this lack of expert consensus, when a panel of experts in economics was asked if a $15 federal minimum wage would increase unemployment, only five percent of the panel had a strong opinion and nearly 40 percent were uncertain.[36] For example, a Chicago Booth professor strongly agreed, an MIT professor disagreed, and a Harvard professor was uncertain. Economics research reflects this. For example, two recent studies of Seattle's minimum wage suggested opposite effects.[37] Proponents argue that raising the minimum wage would increase worker productivity, reduce poverty and income inequality (which is partly due to structural racism and/or sexism), spur economic growth, promote education and self-improvement, and improve employee retention/reduce turnover costs.[38] In contrast, opponents argue that increasing the minimum wage would reduce private sector employment, increase labor costs, lead to small business and industry job loss, and increase outsourcing, unemployment, poverty, and cost of living.[39]

In addition to the often-cited minimum wage debate positions, several additional factors are noteworthy. For example, some argue that it is not an increase to the *federal* minimum wage that is most important, but rather local or regional adjustments. Given the vastly different costs of living across the US, a $7.25 minimum wage affords significantly differing access to essential goods and services. For example, daily parking can cost approximately $35 in Boston or $1 in Cincinnati.[40] Monthly rent may average $4,500 in San Francisco or $870 in Rapid City, SD. Under a regional minimum wage theory, the minimum wage could account for differences in costs of living, set high enough to lift the maximum number of full-time workers out of poverty, but not so high as to increase automation, a reduction in workers' hours, or off-shoring.[41] On the other hand, a federal mandate to increase minimum wages may be necessary to elevate the quality of life that minimum wage affords in areas of the country where systemic racism, sexism, and similar factors have contributed to low wages, and it may be necessary to avoid low-wage areas from being "trapped in a second-tier economy."[42]

Related, wages may fail to adequately compensate workers for the skill and/or risk inherent in their work. A recent study highlighted that skills that are usually associated with managerial and knowledge work, such as critical thinking, active learning, problem-solving, time management, and decision-making, are also important elements of low-wage positions.[43] If undervalued skills were taken into account in determining wages, the average hourly wage was predicted to be $16.52.[44] The undervaluing of low-wage workers takes on heightened relevance in the context of the COVID-19 pandemic. Throughout the COVID-19 pandemic, the US has relied upon essential

workers to perform jobs vital to the economy, under conditions that jeopardize health and safety for workers and their households. Yet, according to the Brookings Institution, essential workers comprised approximately half of all workers in occupations with a median wage of less than $15 per hour, and workers of color are disproportionately impacted.[45] Wages for care workers (e.g., home health aides) are so low that nearly 20 percent of care workers live in poverty, and more than 40 percent rely on some form of public assistance.[46] Factoring public assistance into the minimum wage debate raises another important point: if minimum wage workers are earning so little that they must rely on taxpayer-funded benefits to survive, that is shifting the economic burden from the employers who benefit from employees' time and service to taxpayers. According to recent estimates, raising the federal minimum wage to $15 per hour would reduce government expenditures on public assistance between $13.4 and $31 billion, and the majority of the workers who would benefit from the increased minimum wage are essential and frontline workers.[47]

ADDRESSING ADDITIONAL SDOH TO REDUCE HEALTH IMPACTS OF POVERTY

Income is a critical SDOH, but it is inherently intertwined with other essential SDOH. Affordable housing, transportation, nutritious food, and childcare, as well as educational and job opportunities can be more difficult for low-wage workers to obtain.[48] For example, as affordable housing becomes less accessible in many urban centers, homelessness (a well-established cause of poorer health outcomes) increases, and also causes low-wage workers to move farther from urban centers to access affordable housing. Extended commutes to work increase transportation costs, which decrease the portion of wages remaining to purchase other necessities, such as nutritious food and childcare. Moreover, low-wage work is often unpredictable and inconsistent, which causes many individuals to work multiple jobs, and gives them little control over their schedules. These erratic schedules can trap people in cycles of part-time work, limiting their ability to pursue educational or occupational opportunities, secure safe and affordable childcare, or attend to their health care needs. Accordingly, to increase the economic security of low-wage workers and families living in poverty, alongside minimum wage policy changes, additional changes to address non-occupational SDOH are required, and integrated public health programs can help. Research indicates that minimum wage increases are most successful in decreasing poverty and improving health when they are combined with other structural improvements that maintain or increase the purchasing power of wages.[49] Specifically, policy proposals should also consider public benefit programs, tax credits, job-creation policies,[50] employment programs, career counseling, and education to reduce poverty and improve health and wellbeing.[51] Policies that do not recognize the importance of these multiple SDOH may lead to missed opportunities to improve the economic resources of people in low-income households and advance health equity among the most historically disadvantaged low-wage earners.[52]

It is also essential to consider the unintended consequences incremental increases in minimum wage can have on low-wage workers. While increased wages have the potential to reduce workers' and their families' need for public assistance, minimal increases in wages could be sufficient to reduce or eliminate workers' eligibility for public assistance, but without providing enough in wages to purchase the same basket of goods and services otherwise secured with public assistance, a challenge known as the "benefit cliff." The benefit cliff can harm both employees struggling to meet their basic needs and employers struggling to hire and promote employees.[53] Consider the case of a recent widow with three children. She excelled in her position at a local grocery store, where she earned $15 per hour, and relied on Medicaid and SNAP to help support her family.[54] She was offered a promotion to become a supervisor and earn $18 per hour, but she had to decline the promotion because the increased income would have increased her Medicaid premiums, decreased her SNAP payments, and decreased her tax refund, impairing her ability to provide for her family. Public assistance programs are often rooted in federal statute and administered by federal, state,

and local agencies. To resolve the benefits cliff and optimally support low-wage workers and their employers, these intersecting programs must evolve in concert. Moreover, resolving the benefits cliff is essential to promote equity, as workers of color are disproportionately likely to work in low-wage jobs, and disproportionately likely to rely on public benefits, resulting in higher marginal tax rates, and making it more challenging for families of color living at or near the poverty level to climb the economic ladder. Policymakers striving to reduce poverty must assess how minimum wage policy interacts with other social policies and supports to ensure that new policies do not result in new harm to the low-income populations they want to serve.

AMA POLICY

The AMA has extensive policy on health inequities and diversity, and the AMA continues to provide strong leadership striving to eliminate health care inequities. (Examples include Policies H-65.952, H-65.963, H-350.974, D-350.991, D-350.995, D-420.993, H-65.973, H-60.917, H-440.869, D-65.995, H-150.944, H-185.943, H-450.924, H-350.953, H-350.957, D-350.996, H-350.959). Related, Policy H-280.945 calls for better integration of health care and social services and supports. AMA policy also strongly supports Medicaid. (Examples include Policies H-290.986, D-290.979, D-290.985, and D-290.974). In addition, AMA policy emphasizes the importance of the SDOH and supports focus on the SDOH to improve overall health. (Key examples include Policies H-65.960, D-440.922, H-160.909, H-165.822, and D-440.916).

DISCUSSION

It is essential that the AMA continue to be welcomed into conversations on all sides of policy debates as a trusted, evidence-based advocate for patients and the physicians who care for them. Accordingly, the Council recommends a set of principles that do not prejudge any minimum wage policy proposal, but instead clearly articulate essential variables that any minimum wage policy proposal should explicitly evaluate to ensure that proposals will translate into benefit, and not unanticipated harm, to individuals and communities. Consistent with AMA advocacy efforts, while the AMA is not opposed to the concept of indexing minimum wage to inflation, it wants to ensure that any such proposal has been well-designed to avoid unintended consequences and ensure that the proposal, once implemented, does not result in decreased access to health.

First among the Council's recommended principles is a clear statement that poverty is detrimental to health. Next, the Council recognizes that the value of any set minimum wage will erode with the passage of time, but also recognizes that there are significant complexities and unintended consequences inherent in selecting an index for perpetual minimum wage adjustment. For this reason, the Council recommends a principle that broadly encourages federal, state, and/or local policies regarding minimum wage to include plans for adjusting the minimum wage level in the future and an explanation of how these adjustments can keep pace with inflation. In addition, the Council recommends building on Policies H-65.963 and H-65.960 to place those polices in the context of minimum wage debates. Accordingly, federal, state, and/or local policies regarding minimum wage should be consistent with the AMA's: (1) commitment to speak against policies that create greater health inequities and be a voice for our most vulnerable populations who will suffer the most under such policies, and (2) principle that the highest attainable standard of health, in all its dimensions, is a basic human right and that optimizing the SDOH is an ethical obligation of a civil society.

The Council further appreciates that numerous variables impact the adequacy of a minimum wage for employees, as well as the potential burden on employers. Accordingly, the Council recommends that federal, state, and/or local policies regarding minimum wage should include an

explanation of how variations in geographical cost of living have been considered. Similarly, federal, state, and/or local policies regarding minimum wage should include an estimate of the policy's impact on factors including: unemployment and/or reduction in hours; first-time job seekers; qualification for public assistance (e.g., food, housing, transportation, childcare, health care, etc.); working conditions; health equity, with specific focus on gender and minoritized and marginalized communities; income equity; local small business viability, including independent physician practices; and educational and/or training opportunities.

Finally, the Council emphasizes the importance of viewing income as among the many essential SDOH and the importance of coordinated public health systems to support advances in all SDOH. Accordingly, the Council recommends reaffirming Policy D-440.922, which supports programs and initiatives that strengthen public health systems to address health inequities and the SDOH and Policy H-165.822, which encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 203-N-21 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) affirm that poverty is detrimental to health. (New HOD Policy)

2. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should include plans for adjusting the minimum wage level in the future and an explanation of how these adjustments can keep pace with inflation. (New HOD Policy)

3. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should be consistent with the AMA's commitment to speak against policies that create greater health inequities and be a voice for our most vulnerable populations who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation. (New HOD Policy)

4. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should be consistent with the AMA's principle that the highest attainable standard of health, in all its dimensions, is a basic human right and that optimizing the social determinants of health is an ethical obligation of a civil society. (New HOD Policy)

5. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should include an explanation of how variations in geographical cost of living have been considered. (New HOD Policy)

6. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should include an estimate of the policy's impact on factors including:
    a. Unemployment and/or reduction in hours;
    b. First-time job seekers;
    c. Qualification for public assistance (e.g., food, housing, transportation, childcare, health care, etc.);
    d. Working conditions;

e. Health equity, with specific focus on gender and minoritized and marginalized communities;
f. Income equity;
g. Local small business viability, including independent physician practices; and
h. Educational and/or training opportunities. (New HOD Policy)

7. That our AMA reaffirm Policy D-440.922, which states that the AMA will enhance advocacy and support for programs and initiatives that strengthen public health systems to address health inequities and the social determinants of health. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-165.822, which encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(A-22)

Introduced by: Private Practice Physician Section

Subject: Appeals and Denials – CPT Codes for Fair Compensation

Referred to: Reference Committee G

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1 Whereas, Our American Medical Association (AMA) has previously affirmed that physicians and
2 healthcare practices should be fairly compensated for work involved in administrative work; and
3
4 Whereas, The AMA CPT® Editorial Panel is authorized by the AMA Board of Trustees to revise,
5 update, or modify Current Procedural Terminology (CPT) codes, descriptors, rules, and
6 guidelines; and
7
8 Whereas, Studies have shown that wrongful adverse determinations by health plans are
9 common, including denial of prior authorization, denial of payment for previously provided
10 service; and
11
12 Whereas, Good public and economic policy must align costs, benefits and incentives; currently,
13 all costs in appealing wrongful denials are incurred by healthcare professionals and all financial
14 savings and benefits from wrongful denials accrue to health insurance plans leading to perverse
15 incentive that disadvantage patients and endanger their health; and
16
17 Whereas, Healthcare professionals cannot afford to advocate on patients' behalf to reverse
18 wrongfully denied medically necessary services while health plans have a perverse incentive to
19 deny medically necessary services knowing that healthcare providers cannot afford to appeal
20 every wrongful denial of service; and
21
22 Whereas, Compensation for work performed by healthcare providers is accomplished via CPT
23 codes; therefore be it
24
25 RESOLVED, That our American Medical Association support the creation of CPT codes for
26 consideration by the CPT® Editorial Panel to provide adequate compensation for administrative
27 work involved in successfully appealing denials of services (visits, tests, procedures,
28 medications, devices, and claims), whether pre- or post-service denials, that reflect the actual
29 time expended by physicians and healthcare practices to advocate on behalf of patients, appeal
30 denials, and to comply with insurer and legal requirements and that compensate physicians fully
31 for the time, effort, and legal risks inherent in such work (Directive to Take Action); and be it
32 further
33
34 RESOLVED, That our AMA support the creation of CPT codes for consideration by the CPT
35 Editorial Panel for primary, secondary, and tertiary appeals to independent review organizations
36 (IROs), state and federal regulators, and ERISA plan appeals, including codes for appeals,
37 reconsiderations, and other forms of appeals of adverse determination (Directive to Take
38 Action); and be it further

1 RESOLVED, That our AMA advocate for fair compensation based on CPT codes for appeal of
2 denied services in any model legislation and as a basis for all advocacy for prior authorization
3 reforms. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 03/17/22

RELEVANT AMA POLICY

Remuneration for Physician Services H-385.951
1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly. Citation: Sub. Res. 814, A-96; Reaffirmed: A-02; Reaffirmed: I-08; Reaffirmed: I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmed: A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19

Prior Authorization Reform D-320.982
Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens. Citation: Res. 704, A-19

CPT Coding H-70.992
The AMA continues to support a national uniform descriptor system including, but not limited to, the following initiatives: (1) accelerate the process followed by the AMA CPT Editorial Panel, as feasible, to effect expeditiously changes by adding or deleting codes and nomenclature in order to keep CPT-4 as the best single source for up-to-date reference;
(2) encourage CMS to direct Medicare carriers to refrain from unilateral deletion of CPT descriptors; and
(3) work with national medical specialty societies and state medical associations to review the current status of local carrier descriptor systems and work with CMS to develop an oversight mechanism to monitor carrier compliance with CMS directives on the appropriate use of the national coding system. Citation: Sub. Res. 47, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans D-320.995
(1) Our AMA will re-distribute its model legislation that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization. (2) Our AMA will work with private sector accreditation organizations to ensure that their health plan and utilization management accreditation standards adequately address fair and appropriate mechanisms for retrospective review. (3) AMA's Private Sector Advocacy unit will work with state medical associations, county medical societies, and national medical specialty societies to (a) develop a survey instrument for use by the Federation to gather information from physicians who experience retrospectively denied and/or down-coded claims, (b) seek information on a regular basis from those associations that collect such information, and (c) respond with appropriate legislation, advocacy, and communication initiatives. Citation: CMS Rep. 5, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Sub. Res. 728, A-10; Reaffirmed: A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702
(A-22)

Introduced by: Private Practice Physician Section

Subject: Health System Consolidation

Referred to: Reference Committee G

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1 Whereas, The COVID-19 pandemic resulted in unprecedented human suffering on a scale
2 unbeknownst to modern society since the 1918 Flu Pandemic with over 700,000 Americans
3 dead nationwide while physicians suffered moral injury, burnout, exhaustion, and depression
4 due to a lack of preparedness; and
5
6 Whereas, The healthcare delivery system faced massive operational challenges[1], stimulating
7 policymakers to re-examine care delivery markets, including the harms of health system
8 consolidation and mergers[2]; and
9
10 Whereas, In a large part because of mergers, the majority of Americans now live in highly
11 concentrated health care delivery markets[3], including both hospital systems and health systems,
12 the latter comprised of both outpatient practice chains, hospitals, and other healthcare service
13 markets; and
14
15 Whereas, The harms of healthcare delivery consolidation and mergers are significant and
16 directly negatively affect patients. Specific harms are numerous and well-documented[4],
17 including a lack of quality benefits and decrements in patient experience[5], higher hospital
18 prices[6], decreasing patient access and driving rising health insurance premiums, both of which
19 harm patients; and
20
21 Whereas, Increasing consolidation of physicians into health systems[7,8] decreases physician
22 control over medical practice, hampers independent practice and choices over how and where

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[1] Ramachandran, S., et al; "Coronavirus cases strain New York City hospitals: 'We're getting pounded'"; The Wall Street Journal; May 20, 2020. https://www.wsj.com/articles/coronavirus-cases-strain-new-york-city-hospitals-were-getting-pounded-11584719908 Accessed 10/17/21
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[8] Gibler, K.; et al; "Physician employment: The path forward in the COVID-19 era"; McKinsey & Company; July, 2020; https://www.mckinsey.com/~/media/McKinsey/Industries/Healthcare%20Systems%20and%20Services/Our%20Insights/Physician%20employment%20The%20path%20forward%20in%20the%20COVID%2019%20era/physician-employment-the-path-forward-in-the-covid-19-era.pdf?shouldIndex=false Accessed 10/17/21

physicians practice medicine[9], and places corporations at the center of the patient-physician relationship, thus driving burnout due to a loss of control over the public environment[10]; and

Whereas, Systemic harms of health system and hospital consolidation are more insidious and long-term, including a loss of innovation in care delivery and productivity as manifested by over twenty years of absent labor productivity growth, a finding unparalleled by other industries[11]; and

Whereas, Health care delivery consolidation is a bipartisan problem, acknowledged by both Democrats[12] and Republicans[13]; and

Whereas, The AMA is a national leader in addressing consolidation in healthcare and binging the patient voice to these conversations with its "Competition in health insurance: A comprehensive study of U.S. Markets" now in its twentieth year[14]. The AMA successfully used this study in 2016 to conduct further analyses to assist the U.S. Department of Justice and National Association of Attorneys General to successfully challenge the Anthem-Cigna and Aetna-Humana mergers[15]; therefore be it

RESOLVED, That our American Medical Association undertake an annual report assessing nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing healthcare consolidation for the benefit of patients and physicians who face an existential threat from healthcare consolidation. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/17/22

RELEVANT AMA POLICY

Hospital Consolidation H-215.960
Our AMA: (1) affirms that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority; (2) will continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency; and (3) will work with interested state medical associations

[9] Kane, C.; "Recent changes in physician practice relationships: Private practice dropped to less than 50 percent of physicians in 2020"; American Medical Association; May, 2021; https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf Accessed 10/17/21
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[14] American Medical Association Division of Economic and Health Policy Research; (2021); "Competition in health insurance: A comprehensive study of U.S. Markets – 2021 update"; American Medical Association. https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf Accessed 10/17/21
[15] American Medical Association; "Ensuring health insurance competition"; American Medical Association; https://www.ama-assn.org/delivering-care/patient-support-advocacy/ensuring-health-insurance-competition Accessed 10/17/21

to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.
Citation: CMS Rep. 07, A-19

Health Care Entity Consolidation D-383.980
Our AMA will (1) study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship; and (2) develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities.
Citation: BOT Rep. 8, I-15

Hospital Merger Study H-215.969
1 It is the policy of the AMA that, in the event of a hospital merger, acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues:
(A) medical staff representation on the board of directors;
(B) clinical services to be offered by the institutions;
(C) process for approving and amending medical staff bylaws;
(D) selection of the medical staff officers, medical executive committee, and clinical department chairs;
(E) credentialing and recredentialing of physicians and limited licensed providers;
(F) quality improvement;
(G) utilization and peer review activities;
(H) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges;
(I) conflict resolution mechanisms;
(J) the role, if any, of medical directors and physicians in joint ventures;
(K) control of medical staff funds;
(L) successor-in-interest rights;
(M) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals; and
2. Our AMA will work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services.
Citation: CMS Rep. 5, I-01; Reaffirmed: CMS Rep. 7, A-11; Appended: Res. 3, I-13; Reaffirmed: CMS Rep. 07, A-19

Physicians’ Ability to Negotiate and Undergo Practice Consolidation H-383.988
Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare.
Citation: Res. 299, A-12; Reaffirmed: Res. 206, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703
(A-22)

Introduced by: Maryland, Mississippi

Subject: Mandating Reporting of All Antipsychotic Drug Use in Nursing Home Residents

Referred to: Reference Committee G

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1 Whereas, The federal government does not publicly disclose the use of antipsychotic drugs
2 given to nursing home residents diagnosed with schizophrenia; and
3
4 Whereas, Antipsychotic drugs have historically been used as chemical restraints to keep
5 nursing home residents docile, circumventing the costs associated with additional staffing
6 required to manage nursing home residents; and
7
8 Whereas, Because the Food and Drug Administration has issued “black box” warnings
9 regarding the risks of antipsychotic use among elderly patients with dementia, high rates of
10 antipsychotic drug use can lower a nursing home’s star rating from the federal government, thus
11 damaging the reputation and desirability of the nursing home;[1] and
12
13 Whereas, The percentage of nursing home residents diagnosed with schizophrenia has
14 increased in 2021;[2] and
15
16 Whereas, Nearly one-third of nursing home residents reported in the Centers for Medicare and
17 Medicaid Services (CMS) Minimum Data Set (MDS) as having schizophrenia did not have any
18 evidence of this diagnosis in their Medicare claims history, meaning they were likely prescribed
19 antipsychotic drugs but were excluded because of their diagnosis;[3] and
20
21 Whereas, Current AMA policy “will ask CMS to cease and desist in issuing citations or financial
22 penalties for medically necessary and appropriate use of antipsychotics for the treatment of
23 dementia-related psychosis; and ask CMS to discontinue the use of antipsychotic medication as
24 a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited
25 to medically inappropriate administration of these medications”;[4] therefore be it

RESOLVED, That American Medical Association Policy D-120.951, "Appropriate Use of Antipsychotic Medications in Nursing Home Patients," be amended by addition and deletion to read as follows:

> Our AMA will: (1) meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed and will ask CMS to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis; ~~and~~ (2) ask CMS to discontinue the use of antipsychotic medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications; and (3) ask CMS to require the reporting of all antipsychotic drugs used and the diagnoses for which they are prescribed. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 03/01/22

[1] Five-Star Quality Rating System | CMS https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS (accessed 2021 -09 -21).
[2] MDS 3.0 Frequency Report | CMS https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report (accessed 2021 -09 -21).
[3] CMS Could Improve the Data It Uses to Monitor Antipsychotic Drugs in Nursing Homes, OEI-07-19-00490. 22.
[4] D-120.951 Appropriate Use of Antipsychotic Medications in Nursi | AMA https://policysearch.ama-assn.org/policyfinder/detail/Appropriate%20Use%20of%20Antipsychotic%20Medications%20in%20Nursing%20Home%20Patients%20D-120.951?uri=%2FAMADoc%2Fdirectives.xml-0-77.xml (accessed 2021 -09 -21).

RELEVANT AMA POLICY

Appropriate Use of Antipsychotic Medications in Nursing Home Patients D-120.951
Our AMA will: (1) meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed and will ask CMS to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis; and (2) ask CMS to discontinue the use of antipsychotic medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications.
Res. 523, A-12; Appended: Res. 708, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704
(A-22)

Introduced by: New York

Subject: Employed Physician Contracts

Referred to: Reference Committee G

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1 Whereas, Employed physician contracts contain clauses to the effect that the physician
2 maintains privileges ONLY if the physician remains employed by the hospital/health system; and
3
4 Whereas, An employed physician due to circumstances beyond the physician's control could be
5 dismissed and upon that dismissal, lose all privileges despite having been credentialed
6 according to hospital/health system bylaws; and
7
8 Whereas, Hospital medical staff bylaws ensure rights and due process for all members of the
9 medical staff; therefore be it
10
11 RESOLVED, That our American Medical Association advocate in support of all employed
12 physicians receiving all rights and due process protections afforded all other members of the
13 medical staff. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 03/22/22

RELEVANT AMA POLICY

Fair Process for Employed Physicians H-435.942
1. Our AMA supports whistleblower protections for health care professionals and parties who raise questions that include, but are not limited to, issues of quality, safety, and efficacy of health care and are adversely treated by any health care organization or entity.
2. Our AMA will advocate for protection in medical staff bylaws to minimize negative repercussions for physicians who report problems within their workplace.
Citation: Res. 007, I-16

AMA Principles for Physician Employment H-225.950
1. Addressing Conflicts of Interest
a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
c) In any situation where the economic or other interests of the employer are in conflict with patient

welfare, patient welfare must take priority.
d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and
(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.
e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.
Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession

a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any

other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.
Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.
Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
e) Employers should provide employed physicians with regular performance evaluations, which

should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
(f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
i. The agreement is for the provision of services on an exclusive basis; and
ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.
Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.
6. Payment Agreements
a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.
Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.
Citation: BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19

Physician and Medical Staff Member Bill of Rights H-225.942
Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:
Preamble
The organized medical staff, hospital governing body, and administration are all integral to the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.
The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients. Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians

ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:

a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.

b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.

d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.

e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.

f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:

a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.

b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.

d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts, close medical staff departments, or to transfer patients into, out of, or within the health care organization.

e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.

f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:

a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.

b. The responsibility to provide patient care that meets the professional standards established by the medical staff.

c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.

e. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

f. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
g. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.
h. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care, medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
e. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
f. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
g. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.
h. The right of access to resources necessary to provide clinically appropriate patient care, including the right to participate in advocacy efforts for the purpose of procuring such resources both in collaboration with and independent of the organization's advocacy efforts, without fear of retaliation by the medical staff or the health care organization's administration or governing body.

Citation: BOT Rep. 09, A-17; Modified: BOT Rep. 05, I-17; Appended: Res. 715, A-18; Reaffirmed: BOT Rep. 13, A-19; Modified: BOT Rep. 13, A-21; Modified: CMS Rep. 5, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(A-22)

Introduced by: New York

Subject: Fifteen Month Lab Standing Orders

Referred to: Reference Committee G

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1 Whereas, Federal Medicaid rules limits a laboratory standing order's validity to six months which
2 necessitates practitioners to reorder laboratory studies every six months for regular and routine
3 laboratory studies that often are required for a patient's lifetime (such as standard of care
4 monitoring of HemoglobinA1Cs every three to six months for diabetics); and
5
6 Whereas, There is no documented benefit to limiting laboratory orders to six months and
7 expiration of standing lab orders has led to patient and physician dissatisfaction; and
8
9 Whereas, "Busywork" that is not perceived as meaningful contributes to burnout which is a harm
10 negatively impacting the American medical work force and has deleterious implications on
11 patient care quality, outcomes and patient satisfaction; and
12
13 Whereas, Reordering laboratory studies only for the sake of a regulation leads to unnecessary
14 and not meaningful work, the kind of activity that contributes to burnout among practitioners and
15 increases the cost of healthcare because of the time and labor required for each practice to
16 reorder routine laboratory studies; therefore be it
17
18 RESOLVED, That our American Medical Association advocate the Centers for Medicare and
19 Medicaid Services to allow standing laboratory orders to be active for fifteen (15) months.
20 (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(A-22)

Introduced by: New York

Subject: Government Imposed Volume Requirements for Credentialing

Referred to: Reference Committee G

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1 Whereas, The government will sometimes create volume requirements for credentialing; and
2
3 Whereas, Depending on the details, these requirements may or may not be appropriate and
4 justified; and
5
6 Whereas, The AMA has no policy or guideline for determining whether such requirements would
7 or would not be appropriate; therefore be it
8
9 RESOLVED, That our American Medical Association create guidelines and standards for
10 evaluation of government-imposed volume requirements for credentialing that would include at
11 least the following considerations:
12 (a) the evidence for that volume requirement;
13 (b) how many current practitioners meet that volume requirement;
14 (c) how difficult it would be to meet that volume requirement;
15 (d) the consequences to that practitioner of not meeting that volume requirement;
16 (e) the consequences to the hospital and the community of losing the services of the
17 practitioners who can't meet that volume requirement; and
18 (f) whether volumes of similar procedures could also reasonably be used to satisfy such a
19 requirement. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 03/22/22

RELEVANT AMA POLICY

Reentry into Physician Practice H-230.953
Our AMA encourages: (1) hospitals to establish alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to obtain and maintain credentials and privileges; and (2) The Joint Commission and other accrediting organizations to support alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to obtain and maintain credentials and privileges.
Citation: Res. 717, A-19; Reaffirmed: CMS Rep. 4, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(A-22)

Introduced by: New York

Subject: Insurance Coverage for Scalp Cooling (Cold Cap) Therapy

Referred to: Reference Committee G

Whereas, Scalp Cooling (Cold Cap Therapy) has been cleared by the FDA for use during chemotherapy treatment to reduce the likelihood of chemotherapy-induced alopecia in cancer patients with solid tumors such as ovarian, breast, colorectal, bowel, and prostate cancers; and

Whereas, The National Comprehensive Cancer Network® (NCCN) has given Scalp cooling a Category 2A designation indicating uniform NCCN consensus that the intervention is appropriate; and

Whereas, Peer-reviewed studies have shown Scalp Cooling (Cold Cap Therapy) prevented hair loss in 53-66.3% of patients with breast cancer receiving adjuvant chemotherapy, compared to a control group where all patients experienced significant hair loss; and

Whereas, Scalp cooling treatment (Cold Cap Therapy) in peer reviewed studies was well-tolerated with no scalp metastases observed; and

Whereas, Minimizing hair loss during cancer treatment helps patients to preserve personal identity and self-esteem and appear normal as opposed to sick; and

Whereas, Protecting privacy and gaining the ability to choose whether to disclose a cancer diagnosis is significant to many patients; and

Whereas, Scalp cooling can give patients a sense of control in what can be an overwhelming experience; and

Whereas, The American Medical Association (AMA) has issued two (2) separate Category III CPT codes for "mechanical scalp cooling": 0662T and 0663T, effective July 1, 2020; and

Whereas, Aetna, issued a policy statement in 2017 stating that they consider scalp cooling medically necessary as a means to prevent hair loss during chemotherapy but insurance coverage for scalp cooling is not yet standard in the United States; and

Whereas, Reimbursement varies depending on plan, coverage, and location with some insurance companies covering up to $2,000 for wigs but denying coverage for scalp cooling in similar price range ($1,500-$3,000); and

Whereas, Many patients have encountered the circumstance where their health insurance carrier will not provide coverage for scalp cooling therapy, forcing patients to pay out of pocket for this essential therapy; and

Whereas, This significant out of pocket expense puts this treatment out of range for many; and

Whereas, Our AMA advocates for health equity; therefore be it

RESOLVED, That our American Medical Association advocate for and seek through legislation and/or regulation, universal insurance coverage for Scalp Cooling (Cold Cap) Therapy (Directive to Take Action); and be it further

RESOLVED, That our AMA work with consumer and advocacy groups to challenge insurers on medical necessity denials for Scalp Cooling (Cold Cap) Therapy and encourage appeals to independent third-party reviewers. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

1. NCCN scalp cooling recommendations from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). NCCN provides the following recommendations: breast cancer (Version 1.2019), ovarian caner (Version 1.2020)

References

[1] Trusson D, Pilnick A. The role of hair loss in cancer identity: perceptions of chemotherapy-induced alopecia among women treated for early-stage breast cancer or ductal carcinoma in situ. Cancer Nurs 2017;40:E9e16.
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[6] RugoHS,KleinP,MelinSA,HurvitzSA,MeliskoME,etal.Associationbetween use of a scalp cooling device and alopecia after chemotherapy for breast cancer. JAMA 2017;317:606e14.
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Number: 0290
Policy Effective Date 10/13/1998
Last Review: 7/1/2021
Aetna considers scalp cooling (i.e., using ice-filled bags/bandages, cryogel packs, or specially designed products (e.g., Chemo Cold Cap, DigniCap, ElastoGel, Paxman Scalp Cooling System and Penguin Cold Cap)) medically necessary as a means to prevent hair loss during chemotherapy.
Note: Cooling caps and other products for scalp cooling are considered incidental to the chemotherapy administration and are not separately reimbursed. Cooling caps and other scalp cooling products purchased by the member are considered supplies that are generally excluded from coverage under plans that exclude supplies. See benefit plan descriptions.

RELEVANT AMA POLICY

Symptomatic and Supportive Care for Patients with Cancer H-55.999

Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate

hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.
Citation: CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(A-22)

Introduced by: New York

Subject: Physician Burnout is an OSHA Issue

Referred to: Reference Committee G

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1 Whereas, Repetitive Strain (Stress) Injury or RSI is defined as a category of injuries "to the
2 musculoskeletal and nervous systems that may be caused by repetitive tasks, forceful
3 exertions, vibrations, mechanical compression, or sustained or awkward positions; and
4
5 Whereas, RSI is a known work-related injury which falls under the purview of the Occupational
6 Safety and Health Administration (OSHA); and
7
8 Whereas, Most RSI results from cumulative trauma rather than a single event; and
9
10 Whereas, Repeated exposure to work-related stressors can result in physician burnout; and
11
12 Whereas, Cerebral centers and activity are most certainly within the domain of the nervous
13 system; and
14
15 Whereas, Physician burnout resulting from work-related stressors should be regarded as RSI
16 and, as such, should fall under the aegis of OSHA; therefore be it
17
18 RESOLVED, That our American Medical Association seek legislation/regulation to add
19 physician burnout as a Repetitive Strain (Stress) Injury and subject to Occupational Safety and
20 Health Administration (OSHA) oversight. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709
(A-22)

Introduced by: New York

Subject: Physician Well-Being as an Indicator of Health System Quality

Referred to: Reference Committee G

Whereas, Physician well-being is measurable and existing instruments can assess physician wellness at a system level; and

Whereas, The Triple Aim, now adopted as a set of principles for health system reform within many organizations around the world, fails to acknowledge the critical role of physicians in healthcare transformation and ignores the threats of psychological and physical harm that are common in medical practice; and

Whereas, Intimate caregiving relationships have been reduced to a series of transactional demanding tasks, with a focus on productivity and efficiency, fueled by the pressures of decreasing reimbursement; and

Whereas, These forces have led to an environment which exhibits a lack of teamwork, disrespect between colleagues, and lack of workforce engagement from the level of the front-line caregivers, doctors and nurses, who are burdened with non-caregiving work, to the healthcare leader with bottom-line worries and disproportionate reporting requirements; and

Whereas, By ignoring the experience of providing care in our healthcare delivery framework, this has eliminated consideration of human limitations in the delivery of care and this deficit in the framework of healthcare delivery results in unreasonable expectations upon physicians that affects them personally and the patients they serve; and

Whereas, The Triple Aim framework perpetuates the high occupational stress environment currently experienced by physicians when this framework is followed by all decision makers in healthcare, be they hospital leaders, electronic medical record and other medical device vendors, as well as law makers; and

Whereas, Physician burnout can be a drag on health system quality and outcomes; therefore be it

RESOLVED, That our American Medical Association support policies that acknowledge physician well-being is both a driver and an indicator of hospital and health system quality (New HOD Policy); and be it further

RESOLVED, That our AMA promote dialogue between key stakeholders (physician groups, health-system decision makers, payers, and the general public) about the components needed in such a quality-indicator system to best measure physician and organizational wellness (Directive to Take Action); and be it further

1 RESOLVED, That our AMA (with appropriate resources) develop the expertise to be available to
2 assist in the implementations of effective interventions in situations of suboptimal physician
3 wellness. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 710
(A-22)

Introduced by: New York

Subject: Prior Authorization – CPT Codes for Fair Compensation

Referred to: Reference Committee G

Whereas, The American Medical Association (AMA) has previously affirmed that physicians and physician practices should be fairly compensated for work involved in prior authorizations; and

Whereas, AMA CPT® Editorial Panel is authorized by the AMA Board of Trustees to revise, update, or modify CPT codes, descriptors, rules and guidelines; and

Whereas, Studies have shown that wrongful adverse determinations by health plans are common, including denial of prior authorization and denial of payment for previously provided services; and

Whereas, Costs involved in prior authorizations provide perverse disincentives and lead to sub-optimal healthcare outcomes, especially for marginalized and economically vulnerable communities; and

Whereas, Good public and economic policy must align costs, benefits and incentives; currently, all costs are incurred by physician practices, and all financial savings and benefits from prior authorization accrue to health insurance plans leading to perverse incentives that disadvantage patients and endanger their health; and

Whereas, Compensation for work performed by physician practices is accomplished via CPT codes; therefore be it

RESOLVED, That our American Medical Association include in any model legislation and as a basis for all advocacy, fair compensation based on CPT codes for appeal of wrongfully denied services, including those for prior authorization reforms and that CPT codes must fully reflect the aggregated time and effort expended by physician practices (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate and propose a CPT code for consideration by the CPT® Editorial Panel to account for administrative work involved in prior authorizations that reflects the actual time expended by physician practices to advocate on behalf of patients and to comply with insurer requirements (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate and propose a CPT code for consideration by the CPT® Editorial Panel to account for administrative work that reflects the actual time expended by physician practices and their billing vendors involved in successfully appealing wrongful pre-and post-service denials. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000
Received: 03/22/22

RELEVANT AMA POLICY

Prior Authorization and Utilization Management Reform H-320.939
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.
Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21 Appended: CMS Rep. 5, A-21

Remuneration for Physician Services H-385.951
1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.
Citation: Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19

Prior Authorization Reform D-320.982
Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.
Citation: Res. 704, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 711
(A-22)

Introduced by: New York

Subject: Reducing Prior Authorization Burden

Referred to: Reference Committee G

Whereas, A prescription drug may require an insurance prior authorization; and

Whereas, Patients on chronic therapy experience a change in the rules during the interval between office visits and this results in extra work for a physician to review forms, medical records, complete paperwork, provide documentation and create an entry in the medical record so that a patient's therapy not suffer interruption; and

Whereas, The documentation process can be as resource intensive as a patient encounter; and

Whereas, The prior authorization diverts physician time away from direct patient care, thereby diminishing patient access and physician job satisfaction; and

Whereas, Reducing prior authorizations can protect patients from unnecessary delays in care; therefore be it

RESOLVED, That our American Medical Association seek regulation or legislation that:

- restricts insurance companies from requiring prior authorizations for generic medications;
- contains disincentives for insurers demanding unnecessary prior authorizations, including payments to physicians' practices for inappropriate prior authorizations;
- requires payment be made to the physician practice for services related to prior authorization when those services do not coincide with a visit; and
- ensures a requirement for an independent external review organization to review disputes involving prior authorizations and require insurer payments be made to the practice when the review organization agrees with the physician practice. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 712
(A-22)

Introduced by: New York

Subject: The Quadruple Aim – Promoting Improvement in the Physician Experience of Providing Care

Referred to: Reference Committee G

Whereas, In 2008, Donald Berwick and the Institute of Healthcare Improvement provided a framework for the delivery of high value care in the USA, the *Triple Aim*, centered around three overarching goals: improving the individual experience of care; improving the health of populations; and reducing the per capita cost of healthcare; and

Whereas, The *Triple Aim*, adopted as a set of principles for health system reform within many organizations around the world, fails to acknowledge the critical role of physicians in healthcare transformation and ignores the threats of psychological and physical harm that are common in medical practice; and

Whereas, For decision makers in healthcare (hospital leaders, EMR and other medical vendors, lawmakers and insurance companies) to abide by the *Triple Aim* is to ignore the threats of psychological and physical harm that are common to [clinicians] and patients; and

Whereas, The focus on productivity and efficiency, fueled by the pressures of decreasing reimbursement, has reduced intimate caregiving relationships to a series of transactional demanding tasks; and

Whereas, That by ignoring the experience of providing care in our healthcare delivery framework, this has eliminated consideration of human limitations in the delivery of care and this deficit in the framework of healthcare delivery results in unreasonable expectations upon physicians that affects them personally and the patients they serve; and

Whereas, The *Triple Aim* framework perpetuates the high occupational stress environment currently experienced by physicians when this framework is followed by all decision makers in healthcare, be they hospital leaders, electronic medical record and other medical device vendors, as well as law makers; and

Whereas, Intimate caregiving relationships have been reduced to a series of transactional demanding tasks, with a focus on productivity and efficiency, fueled by the pressures of decreasing reimbursement; therefore be it

RESOLVED, That to the *Triple Aim* which was established by Dr. Berwick and the Institute of Healthcare Improvement, our American Medical Association adopt a fourth goal: namely the goal of improving physicians' experience in providing care. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 713
(A-22)

Introduced by: Private Practice Physician Section

Subject: Enforcement of Administrative Simplification Requirements - CMS

Referred to: Reference Committee G

Whereas, Our American Medical Association has previously affirmed that administrative simplification, including automation and standardization of electronic transactions, is a high priority in order to provide affordable, timely, and effective care; and

Whereas, The National Standards Group (NSG) at the Centers for Medicare and Medicaid Services (CMS) Office of Burden Reduction is empowered to enforce administrative simplification requirements to ensure standardization throughout the ecosystem of payers, physicians, and clearinghouses; and

Whereas, Violations of administrative simplification requirements by health plans and payer business associates, including clearinghouses, are prevalent and have an adverse effect on healthcare practices and patients via higher costs and resulting in limited access to affordable healthcare; and

Whereas, The NSG at the CMS Office of Burden Reduction has stated that the enforcement mechanism against health plan violations is based on the idea of “voluntary compliance,” the only program of this type in the federal government where compliance is “voluntary;” and

Whereas, The NSG at the CMS Office of Burden Reduction has failed to impose any financial penalties in the past seven years on health plans for violation of HIPAA administrative simplification requirements while at the same time, CMS imposed numerous penalties on physicians and the healthcare producer industry, including for violations of HIPAA privacy rules which are governed by the same rules as the HIPAA administrative simplification requirements, MACRA MIPS penalties, “Open Payments” Sunshine Act violation penalties, and numerous other financial penalties; therefore be it

RESOLVED, That our American Medical Association take the position that the failure by the National Standards Group at the Centers for Medicare and Medicaid Services Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans is clearly unacceptable (New HOD Policy); and be it further

RESOLVED, That our AMA take the position that the National Standards Group at the Centers for Medicare and Medicaid Services Office of Burden Reduction practices of closing complaints without further investigation and ignoring overwhelming evidence that contradicts health plan assertions is also unacceptable (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for enhanced enforcement of the HIPAA Administrative Simplification requirements for health plans. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/17/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 714
(A-22)

Introduced by: Organized Medical Staff Section

Subject: Prior Authorization Reform for Specialty Medications

Referred to: Reference Committee G

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1 Whereas, Since the inception of prior authorization (PA) requirements it has been a strategic
2 priority of the AMA to improve efficiency in the process to prevent delays in treatment; and
3
4 Whereas, In spite of attempts to specialize PA forms, approval is often delayed for the following
5 reasons: 1) insurers often require information that was not part of the original PA form, and 2)
6 information submitted to the pharmacy PA manager isn't made available to other offices
7 involved in the PA system; and
8
9 Whereas, It is painfully clear that market forces often drive the PA process; i.e. during the
10 Covid-19 pandemic the price of Planquenil (hydroxychloroquine) increased and a restriction was
11 placed on the number of pills dispensed monthly at a substandard level. The insurer not the
12 physician is now writing the orders. Although we now have studies that demonstrate a limited
13 value of Planquenil in critically ill ICU Covid patients, this restriction in dispensing continues at
14 the present time; and
15
16 Whereas, A delay in receiving medications on a timely basis and in adequate doses has
17 resulted in many patients experiencing flare-ups in their diseases; and
18
19 Whereas, The PA process has greatly increased the burden on medical practices often
20 requiring ten to fifteen hours weekly to obtain approval for the physician's order; and
21
22 Whereas, Even a medical staff person well-trained in obtaining PAs often requires the help of
23 the physician to complete; and
24
25 Whereas, The peer-to-peer review component of the PA process is problematic because the
26 physician reviewer often does not have access to the original information submitted, thus
27 requiring the resending of the information and creating further delay of the process; therefore be it
28
29 RESOLVED, That our American Medical Association encourage Congress and the President to
30 issue a moratorium on the specialty medicine prior authorization process for one year to allow
31 further study (New HOD Policy); and be it further
32
33 RESOLVED, That our AMA work with other stakeholders to encourage pharmaceutical
34 companies and other entities that offer assistance programs to increase eligibility for their
35 assistance programs. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/17/22

RELEVANT AMA POLICY

Prior Authorization and Utilization Management Reform H-320.939
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.
Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21

Prior Authorization Reform D-320.982
Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.
Citation: Res. 704, A-19

Approaches to Increase Payer Accountability H-320.968
Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.
(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions;
(b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)
(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release

of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.
(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.
Citation: BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMD Rep. 4, A-95; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMD Rep. 13, I-98; Reaffirmed: I-98; Reaffirmed: A-99; Reaffirmed: I-99; Reaffirmed: A-00; Reaffirmed in lieu of Res. 839, I-08, Reaffirmed: A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmed: A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed in lieu of Res. 242, A-17; Reaffirmed in lieu of Res. 106, A-17; Reaffirmed: A-17; Reaffirmed: I-17; Reaffirmed: A-18; Reaffirmed: A-19; Reaffirmed: Res. 206, I-20

Opposition to Prescription Prior Approval D-125.992
Our AMA will urge public and private payers who use prior authorization programs for prescription drugs to minimize administrative burdens on prescribing physicians.
Citation: Sub. Res. 529, A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed: CMS Rep. 1, A-21

Administrative Simplification in the Physician Practice D-190.974
1. Our AMA strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.
5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.
6. Our AMA will continue its efforts to ensure that physicians are aware of the value of automating their claims cycle.
Citation: CMS Rep. 8, I-11; Appended: Res. 811, I-12; Reaffirmed: A-14; Reaffirmed: A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 805, I-16; Reaffirmed: I-17; Reaffirmed: A-19; Modified: CMS Rep. 09, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 715
(A-22)

Introduced by: Private Practice Physician Section

Subject: Prior Authorization – CPT Codes for Fair Compensation

Referred to: Reference Committee G

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1 Whereas, Our AMA has previously affirmed that physicians and healthcare practices should be
2 fairly compensated for work involved in prior authorizations; and
3
4 Whereas, The AMA CPT® Editorial Panel is authorized by the AMA Board of Trustees to revise,
5 update, or modify Current Procedural Terminology (CPT) codes, descriptors, rules, and
6 guidelines; and
7
8 Whereas, Studies have shown that costs involved in prior authorizations provide perverse
9 disincentives and lead to sub-optimal healthcare outcomes, especially for marginalized and
10 economically vulnerable communities; and
11
12 Whereas, Good public and economic policy must align costs, benefits, and incentives; currently,
13 all costs are incurred by healthcare providers and all financial savings and benefits from prior
14 authorization accrue to health insurance plans, leading to perverse incentives to impose more
15 and more prior authorization requirements that are of questionable clinical benefit; and
16
17 Whereas, Compensation for work performed by healthcare providers is accomplished via CPT
18 codes; therefore be it
19
20 RESOLVED, That our American Medical Association support the creation of CPT codes to
21 provide adequate compensation for administrative work involved in prior authorizations,
22 including pre-certifications and prior notifications, that reflects the actual time expended by
23 physicians and healthcare practices to advocate on behalf of patients and to comply with insurer
24 requirements and that compensates physicians fully for the time, effort, and legal risks inherent
25 in such work (New HOD Policy); and be it further
26
27 RESOLVED, That our AMA advocate for CPT codes to be developed for prior authorizations to
28 fully reflect the aggregated time and effort involved in prior authorization, including multiple
29 contracts, wait time on the phone, chat, or other platforms preferred by payers or their agents,
30 among other costs to physician practice (New HOD Policy); and be it further
31
32 RESOLVED, That our AMA advocate for fair compensation based on CPT codes for prior
33 authorization in any model legislation and as a basis for all advocacy for prior authorization
34 reforms. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 03/17/22

RELEVANT AMA POLICY

Remuneration for Physician Services H-385.951
1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.
Citation: Sub. Res. 814, A-96; Reaffirmed: A-02; Reaffirmed: I-08; Reaffirmed: I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmed: A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19

Prior Authorization Reform D-320.982
Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.
Citation: Res. 704, A-19

CPT Coding H-70.992
The AMA continues to support a national uniform descriptor system including, but not limited to, the following initiatives: (1) accelerate the process followed by the AMA CPT Editorial Panel, as feasible, to effect expeditiously changes by adding or deleting codes and nomenclature in order to keep CPT-4 as the best single source for up-to-date reference;
(2) encourage CMS to direct Medicare carriers to refrain from unilateral deletion of CPT descriptors; and (3) work with national medical specialty societies and state medical associations to review the current status of local carrier descriptor systems and work with CMS to develop an oversight mechanism to monitor carrier compliance with CMS directives on the appropriate use of the national coding system.
Citation: Sub. Res. 47, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 716
(A-22)

Introduced by: Organized Medical Staff Section

Subject: Discharge Summary Reform

Referred to: Reference Committee G

Whereas, Our ability to do complicated surgical and medical procedures is unprecedented, with the aid of electronic medical records our ability to produce a logical, concise, and accurate discharge summary has deteriorated to the point of nonexistence; and

Whereas, Current discharge summaries can be over 100 pages long and contain a multitude of completely unnecessary information; and

Whereas, Incomprehensible, bloated discharge summaries are a significant patient hazard since physicians resuming care of the patient find it nearly impossible to determine discharge diagnosis, hospital course, procedures performed, medications prescribed, or follow-up care; and

Whereas, All medical students and residents have been taught how to dictate and produce a discharge summary in their training which includes discharge diagnosis, procedures performed, hospital course, pertinent lab and radiology findings, discharge medications, and follow-up care; and

Whereas, All the equipment to produce a competent discharge summary is currently in place since surgeons still use the equipment to produce an operation note; therefore be it

RESOLVED, That our American Medical Association coordinate with the American Hospital Association with input from the Centers for Medicare & Medicaid Services and other professional organizations as appropriate to revive the concise discharge summary that existed prior to electronic medical records for the sake of much improved patient care and safety (Directive to Take Action); and be it further

RESOLVED, That our AMA internally develop a model hospital discharge summary in such a manner as to be concise but informational, include to promote excellent, safe patient care and improve coordinated discharge planning. This model use shall be promoted to our AMA and federation of medicine colleagues. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 03/17/22

RELEVANT AMA POLICY

Hospital Discharge Communications H-160.902
1. Our AMA encourages the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization.
2. Our AMA encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care.
3. Our AMA encourages hospital engagement of patients and their families/caregivers in the discharge process, using the following guidelines:
a. Information from patients and families/caregivers is solicited during discharge planning, so that discharge plans are tailored to each patient's needs, goals of care and treatment preferences.
b. Patient language proficiency, literacy levels, cognitive abilities and communication impairments (e.g., hearing loss) are assessed during discharge planning. Particular attention is paid to the abilities and limitations of patients and their families/caregivers.
c. Specific discharge instructions are provided to patients and families or others responsible for providing continuing care both verbally and in writing. Instructions are provided to patients in layman's terms, and whenever possible, using the patient's preferred language.
d. Key discharge instructions are highlighted for patients to maximize compliance with the most critical orders.
e. Understanding of discharge instructions and post-discharge care, including warning signs and symptoms to look for and when to seek follow-up care, is confirmed with patients and their families/caregiver(s) prior to discharge from the hospital.
4. Our AMA supports making hospital discharge instructions available to patients in both printed and electronic form, and specifically via online portals accessible to patients and their designated caregivers.
5. Our AMA supports implementation of medication reconciliation as part of the hospital discharge process. The following strategies are suggested to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged:
a. All discharge medications, including prescribed and over-the-counter medications, should be reconciled with medications taken pre-hospitalization.
b. An accurate list of medications, including those to be discontinued as well as medications to be taken after hospital discharge, and the dosage and duration of each drug, should be communicated to patients.
c. Medication instructions should be communicated to patients and their families/caregivers verbally and in writing.
d. For patients with complex medication schedules, the involvement of physician-led multidisciplinary teams in medication reconciliation including, where feasible, pharmacists should be encouraged.
6. Our AMA encourages patient follow-up in the early time period after discharge as part of the hospital discharge process, particularly for medically complex patients who are at high-risk of re-hospitalization.
7. Our AMA encourages hospitals to review early readmissions and modify their discharge processes accordingly.
Citation: CMS Rep. 07, I-16

Evidence-Based Principles of Discharge and Discharge Criteria H-160.942
(1) The AMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process by following the principle that the needs of patients must be matched to settings with the ability to meet those needs.
(2) The AMA calls on physicians, specialty societies, insurers, and other involved parties to join

in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients and that are flexible to meet advances in medical and surgical therapies and adapt to local and regional variations in health care settings and services.
(3) The AMA encourages incorporation of discharge criteria into practice parameters, clinical guidelines, and critical pathways that involve hospitalization.
(4) The AMA promotes the local development, adaption and implementation of discharge criteria.
(5) The AMA promotes training in the use of discharge criteria to assist in planning for patient care at all levels of medical education. Use of discharge criteria will improve understanding of the pathophysiology of disease processes, the continuum of care and therapeutic interventions, the use of health care resources and alternative sites of care, the importance of patient education, safety, outcomes measurements, and collaboration with allied health professionals.
(6) The AMA encourages research in the following areas: clinical outcomes after care in different health care settings; the utilization of resources in different care settings; the actual costs of care from onset of illness to recovery; and reliable and valid ways of assessing the discharge needs of patients.
(7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process:
(a) As tools for planning patients' transition from one care setting to another and for determining whether patients are ready for the transition, discharge criteria are intended to match patients' care needs to the setting in which their needs can best be met.
(b) Discharge criteria consist of, but are not limited to: (i) Objective and subjective assessments of physiologic and symptomatic stability that are matched to the ability of the discharge setting to monitor and provide care. (ii) The patient's care needs that are matched with the patient's, family's, or caregiving staff's independent understanding, willingness, and demonstrated performance prior to discharge of processes and procedures of self care, patient care, or care of dependents. (iii) The patient's functional status and impairments that are matched with the ability of the care givers and setting to adequately supplement the patients' function. (iv) The needs for medical follow-up that are matched with the likelihood that the patient will participate in the follow-up. Follow-up is time-, setting-, and service-dependent. Special considerations must be taken to ensure follow-up in vulnerable populations whose access to health care is limited.
(c) The discharge process includes, but is not limited to: (i) Planning: Planning for transition/discharge must be based on a comprehensive assessment of the patient's physiological, psychological, social, and functional needs. The discharge planning process should begin early in the course of treatment for illness or injury (prehospitalization for elective cases) with involvement of patient, family and physician from the beginning. (ii) Teamwork: Discharge planning can best be done with a team consisting of the patient, the family, the physician with primary responsibility for continuing care of the patient, and other appropriate health care professionals as needed. (iii) Contingency Plans/Access to Medical Care: Contingency plans for unexpected adverse events must be in place before transition to settings with more limited resources. Patients and caregivers must be aware of signs and symptoms to report and have a clearly defined pathway to get information directly to the physician, and to receive instructions from the physician in a timely fashion. (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, he or she is responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which

the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred. (v) Communication: Transfer of all pertinent information about the patient (such as the history and physical, record of course of treatment in hospital, laboratory tests, medication lists, advanced directives, functional, psychological, social, and other assessments), and the discharge summary should be completed before or at the time of transfer of the patient to another setting. Patients should not be accepted by the new setting without a copy of this patient information and complete instructions for continued care. (8) The AMA supports the position that the care of the patient treated and discharged from a treating facility is done through mutual consent of the patient and the physician; and (9) Policy programs by Congress regarding patient discharge timing for specific types of treatment or procedures be discouraged.
Citation: CSA Rep. 4, A-96; Reaffirmation I-96; Modified by Res. 216, A-97; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 1, A-08; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 16, A-19

Activities of The Joint Commission and a Single Signature to Document the Validity of the Contents of the Medical Record H-225.965
The AMA supports the authentication of the following important entries in the medical record, history and physical examinations, operative procedures, consultations,
and discharge summaries. Unless otherwise specified by the hospital or medical staff bylaws, or as required by law or regulation, a single signature may document the validity of other entries in the medical record.
Citation: BOT Rep. 58, A-96; Reaffirmed: CLRPD Rep. 2, A-06; Modified: CMS Rep. 01, A-16; Reaffirmed: I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 717
(A-22)

Introduced by: Resident and Fellow Section

Subject: Expanding the AMA's Study on the Economic Impact of COVID-19

Referred to: Reference Committee G

Whereas, The 2019 Coronavirus Disease (COVID-19) pandemic has had a large impact on healthcare spending, utilization, and employment; and

Whereas, The American healthcare system and hospital revenue drastically declined as a result of COVID-19, experiencing monthly financial losses on average exceeding $50 billion dollars during the earliest months of the COVID-19 pandemic;[1] and

Whereas, It has been estimated that the cancellation of elective surgeries and procedures as a result of the COVID-19 pandemic could cost the healthcare system and hospitals $20-50 billion in revenue each month, with monthly net income losses exceeding $5 billion dollars[1,2,3]; and

Whereas, The economic support for offsetting the financial strain of the COVID-19 pandemic that was provided by the 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act likely disadvantaged healthcare systems treating at-risk populations because it initially used a formula based on Medicare fee-for-service billings to distribute financial aid to hospitals[3,4]; and

Whereas, Urban and rural hospitals, and other medical centers that disproportionately treat underserved populations may face higher existential threats due to lost revenue, higher costs, and other the economic burdens incurred during the COVID-19 pandemic[3,5]; and

Whereas, The economic impact on residents and fellows seems to have been significant regarding job loss[6]; and

Whereas, The AMA has become a predominant source of information regarding the economic impact on physicians and their practices during the COVID-19 pandemic[7,8]; and

Whereas, The AMA has yet to study how the economic impact of the COVID-19 pandemic on hospitals, clinics, surgeons, students, residents, fellows, and patients with respect to lost revenue and unanticipated healthcare costs; therefore be it

RESOLVED, That our American Medical Association work with relevant organizations and stakeholders to study the economic impact and long-term recovery of the COVID-19 pandemic on healthcare institutions in order to identify and better understand which groups of physicians, patients and organizations may have been disproportionately affected by the financial burdens of the COVID-19 pandemic (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant organizations and stakeholders to study the overall economic impact of office closures, cancellations of elective surgeries and interruptions in patient care, as well as the economic impact of utilizing telemedicine for an increasing percentage of patient care. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/04/22

References:
1. American Hospital Association. Hospitals and Health Systems Face Unprecedented Financial Pressures Due to COVID-19. 2020. Available at https://www.aha.org/system/files/media/file/2020/05/aha-covid19-financial-impact-0520-FINAL.pdf.
2. Best MJ, McFarland EG, Anderson GF, Srikumaran U. The likely economic impact of fewer elective surgical procedures on US hospitals during the COVID-19 pandemic. Surgery.
3. Bose SK, Dasani S, Serena D, Roberts S, Wirtalla C, DeMatteo R, Doherty G, Kelz R. The Cost of Quarantine. Annals of Surgery. 2021; 273(5):844-849.
4. CARES Act Provider Relief Fund: For Providers. 2020. Available at: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/for-providers/index.html
5. Tonna JE, Hanson HA, Cohan JN, et al. Balancing revenue generation with capacity generation: case distribution, financial impact and hospital capacity changes from cancelling or resuming elective surgeries in the US during COVID-19. BMC Health Serv Res. 2020;20(1):1119.
6. 2020 Review of Physicians and Advanced Practitioner Recruiting Incentives and the Impact of COVID-19. Merritt Hawkins. 2020. https://www.merritthawkins.com/uploadedfiles/merritthawkins_2020_incentive_review.pdf
7. American Medical Association. COVID-19 Financial Impact on Physician Practices. 2020. Available at https://www.ama-assn.org/practice-management/sustainability/covid-19-financial-impact-physician-practices
8. Gillis K. Changes in Medicare Physician Spending During the COVID-19 Pandemic. American Medical Association Policy Research Perspectives. 2021. Available at Policy Research Perspectives: Changes in Medicare physician spending during the COVID-19 pandemic (ama-assn.org)

RELEVANT AMA POLICY

Physician Payment Advocacy for Additional Work and Expenses Involved in Treating Patients During the Covid-19 Pandemic and Future Public Health Emergencies D-390.947

Our AMA: (1) will work with interested national medical specialty societies and state medical associations to advocate for regulatory action on the part of the Centers for Medicare & Medicaid Services to implement a professional services payment enhancement, similar to the HRSA COVID-19 Uninsured Program, to be drawn from additional funds appropriated for the public health emergency to recognize the additional uncompensated costs associated with COVID-19 incurred by physicians during the COVID-19 Public Health Emergency; (2) will work with interested national medical specialty societies and state medical associations to continue to advocate that the Centers for Medicare & Medicaid Services and private health plans compensate physicians for the additional work and expenses involved in treating patients during a public health emergency, and that any new payments be exempt from budget neutrality; and (3) encourages interested parties to work in the CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC) processes to continue to develop coding and payment solutions for the additional work and expenses involved in treating patients during a public health emergency.
Citation: Res. 114, I-20

Creating a Congressionally-Mandated Bipartisan Commission to Examine the U.S. Preparations for and Response to the COVID-19 Pandemic to Inform Future Efforts D-440.923

1. Our AMA will advocate for passage of federal legislation to create a congressionally-mandated bipartisan commission composed of scientists, physicians with expertise in pandemic preparedness and response, public health experts, legislators and other stakeholders, which is to examine the U.S. preparations for and response to the COVID-19 pandemic, in order to inform and support future public policy and health systems preparedness.
2. In advocating for legislation to create a congressionally-mandated bipartisan commission, our AMA will seek to ensure key provisions are included, namely that the delivery of a specific end product (i.e., a report) is required by the commission by a certain period of time, and that adequate funding be provided in order for the commission to complete its deliverables.
Citation: Res. 211, I-20

Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953
In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt.
Citation: Res. 202, I-20

Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-385.951
Our AMA and the federation of medicine will work to improve and expand various federal stimulus programs (e.g., the CARES Act and MAPP) in order to assist physicians in response to the Covid-19 pandemic, including:
● Restarting the suspended Medicare Advance payment program, including significantly reducing the re-payment interest rate and lengthening the repayment period;
● Expanding the CARES Act health care provider relief pool and working to ensure that a significant share of the funding from this pool is made available to physicians in need regardless of the type of patients treated by those physicians; and
● Reforming the Paycheck Protection Program, to ensure greater flexibility in how such funds are spent and lengthening the repayment period.
Citation: Res. 202, I-20

Crisis Payment Reform Advocacy D-405.979
Our AMA will continue to promote national awareness of the loss of physician medical practices and patient access to care due to COVID-19, and continue to advocate for reforms that support and sustain physician medical practices.
Citation: Res. 218, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 718
(A-22)

Introduced by: Illinois

Subject: Degradation of Medical Records

Referred to: Reference Committee G

Whereas, Medical records have traditionally served to help the physician in the care of patients; and

Whereas, The electronic health record (EHR) was initially viewed and welcomed as an asset assisting the care of patients; and

Whereas, EHRs have not been an asset in assisting in the care of patients because of the subsequently mandated and marked increase in documentation which effectively obliterated the intended benefit; and

Whereas, Adding the additional component of data entry to patient visits was apparently done without providing financial reimbursement for the required time to complete; and

Whereas, The reality is that the need for extra data entry often impairs the physician's ability to care for the patient given the time pressure of the appointments; and

Whereas, The burden of documentation impairs the doctor-patient relationship; and

Whereas, The doctor-patient relationship has been a major incentive to practice primary care medicine; and

Whereas, There is power in nomenclature and language; and

Whereas, Mandated EHR documentation now more accurately represents "insurance and government reports" rather than "medical records" in the traditional sense; therefore be it

RESOLVED, That our American Medical Association publish available data about the amount of time physicians spend on data entry versus direct patient care, in order to inform patients, insurers, and prospective primary care physicians about the real expectations of the medical profession. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 04/07/22

RELEVANT AMA POLICY

D-478.966 - Understanding and Correcting Imbalances in Physician Work Attributable to Electronic Health Records
Our AMA will work with health care leaders and policymakers to use industrial engineering principles and evidence-based best practices to study and then propose systematic reforms to reduce physicians' electronic health record workload. Alt. Res. 716, A-17

H-478.981 - Health Information Technology Principles
Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:
1. Enhance physicians' ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.

Our AMA will AMA utilize HIT principles to:
1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of "Information Blocking."

Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules. BOT Rep. 19, A-18 Reaffirmation: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 719
(A-22)

Introduced by: Ohio

Subject: System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access

Referred to: Reference Committee G

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1 Whereas, The time and effort spent on prior authorization is a burden which negatively impacts
2 the time physicians can spend caring for patients, negatively impacts the resiliency of
3 physicians and the ability to provide high quality access to all patients; and
4
5 Whereas, The AMA has policy prioritizing advocacy to ease prior authorization burdens and
6 further advance prior authorization reforms (H-320.939, D-285.960); and
7
8 Whereas, Current AMA policy, H-320.939, D-285.960 and related policies, have neither
9 satisfactorily unyoked the practicing physicians' burdens on the topic of prior authorizations, nor
10 created widespread real-time authentication best practice applications as may be seen in other
11 industries, and
12
13 Whereas, Health care insurers and Medicaid/Medicare Products have communication systems
14 that cause excessive response times through creation of websites that are difficult to navigate,
15 and submissions to these websites have neither a response to submissions nor a received
16 confirmation; and
17
18 Whereas, Prior authorization websites are inherently dysfunctional and promote delay, through
19 excessive downtime, phone systems that take an average of 45 minutes or often greater than
20 85 minutes in order to speak to a human insurance specialist, a high rate of disconnection while
21 waiting on the phone with no call back option, limitation of the number of patients that can be
22 authorized upon waiting with instructions to call back again to authorize other patients, Prior
23 Authorization taking up to 14 days from the time submitted to await a decision, etc. to just name
24 a few; and
25
26 Whereas, There is no overseeing entity to review these unfair business practices which are
27 substandard as compared with other entities who have upgraded their business models to
28 ensure end user functionality and efficiency; and
29
30 Whereas, It appears that these business practices by Health Care Insurers and
31 Medicaid/Medicare Products are indirectly limiting, restricting or delaying patient care and
32 unintentionally rationing of health care services; therefore be it
33
34 RESOLVED, That our American Medical Association encourage and advocate health care
35 insurers and Medicare/Medicaid Products to ensure that the systems of communication for prior
36 authorization include: live personnel access, simplification of website navigation, immediate
37 response with confirmation number of submission and an expedient decision for authorizations.
38 (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000
Received: 04/08/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 720
(A-22)

Introduced by: Illinois

Subject: Mitigating the Negative Impact of Step Therapy Policies and Nonmedical Switching of Prescription Drugs on Patient Safety

Referred to: Reference Committee G

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1 Whereas, Insurance companies use pharmaceutical step therapy programs and non-medical
2 drug switching policies as means to control costs; and
3
4 Whereas, These policies can serve to try to replace a physician's judgment and interfere with
5 the doctor-patient relationship; and
6
7 Whereas, These policies can restrict patient access to effective treatments, putting patient
8 health and safety in jeopardy by subjecting patients to potential adverse effects, and absorbing
9 practice resources with burdensome approvals and documentation requirements; and
10
11 Whereas, The process of nonmedical drug switching mandates that a patient go off their current
12 therapies for no other reason than to save money, which can include increasing out-of-pocket
13 costs, moving treatments to higher cost tiers or terminating coverage of a particular drug; and
14
15 Whereas, The American College of Physicians (ACP) has recognized the need to balance costs
16 and that any such programs should contain flexibilities so that physicians can, based on their
17 knowledge of a patient's status and co-morbid conditions, be able to easily deviate from the
18 usual approach to optimize patient care and minimize disruptions to effective care; and
19
20 Whereas, The ACP has adopted recommendations to help physicians and patients who are
21 subjected to these types of policies; therefore be it

RESOLVED, That our American Medical Association adopt policy supporting the recommendations of the American College of Physicians with respect to insurance step therapy and nonmedical drug switching policies, including:

- All step therapy and medication switching policies should aim to minimize care disruption, harm, side effects and risks to the patient.

- All step therapy and nonmedical drug switching policies should be designed with patients at the center, while accounting for unique needs and preferences.

- All step therapy and nonmedical drug switching protocols should be designed with input from frontline physicians and community pharmacists; feature transparent, minimally burdensome processes that consider the expertise of a patient's physician; and include a timely appeals process.

- Data concerning the effectiveness and potential adverse consequences of step therapy and nonmedical drug switching programs should be made transparent to the public and studies by policymakers. Alternative strategies to address the rising cost of prescription drugs that do not inhibit patient access to medications should be explored. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 721
(A-22)

Introduced by: Resident and Fellow Section

Subject: Amend AMA Policy H-215.981, "Corporate Practice of Medicine"

Referred to: Reference Committee G

Whereas, The American Academy of Emergency Medicine released a statement on the corporate practice of medicine and the effects on physician education, patient care and the physician-patient relationship[1]; and

Whereas, The corporatization of medicine, at the expense of high quality, safe healthcare, has led to physicians being fired and replaced by mid-level providers, especially in states that allow independent practice for mid-level providers[2]; and

Whereas, The corporate practice of medicine has led to situations in which physicians are expected to provide on-the-job training to mid-level providers before being dismissed, in effect "training their replacements"[2]; and

Whereas, Postgraduate programs for mid-level providers have expanded at a rate far greater than for physician post-graduate training programs[2]; therefore be it

RESOLVED, That our American Medical Association amend policy H-215.981, "Corporate Practice of Medicine," by addition to read as follows:

> 4. Our AMA acknowledges that the corporate practice of medicine has led to the erosion of the physician-patient relationship, erosion of physician-driven care and created a conflict of interest between profit and training the next generation of physicians. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

References:

1. New Position Statement: State of Emergency Medicine | AAEM - American Academy of Emergency Medicine
Al-Agba, Niran, and Rebekah Bernard. *Patients at Risk: the Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Universal-Publishers, Inc., 2020.

RELEVANT AMA POLICY

Corporate Practice of Medicine H-215.981
1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.
2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.
3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.
Citation: Res. 247, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Modified: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 07, A-17; Modified: Res. 713, A-18; Reaffirmed: CMS Rep. 11, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 722
(A-22)

Introduced by: Oklahoma

Subject: Eliminating Claims Data for Measuring Physician and Hospital Quality

Referred to: Reference Committee G

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

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

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

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

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

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

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

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

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

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

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

RESOLVED, That our AMA collaborate with CMS and other stakeholders to eliminate the use of claims data for measuring physician and hospital quality. (Directive to Take Action)

Reference: https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2757527?resultClick=1

Fiscal Note: Modest - between $1,000 - $5,000

Received: 04/26/22

Informational Reports

BOT Report(s)

03 2021 Grants and Donations
05 Update on Corporate Relationships
06 Redefining AMA's Position on ACA and Healthcare Reform
07 AMA Performance, Activities and Status in 2021
08 Annual Update on Activities and Progress in Tobacco Control: March 2021 through February 2022
10 American Medical Association Center for Health Equity Annual Report
12 Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent
19 Demographic Report of the House of Delegates and AMA Membership

CEJA Opinion(s)

01 Amendment to E-1.1.6, Quality
02 Amendment to E-1.2.11, Ethical Innovation in Medical Practice
03 Amendment to E-11.1.2, Physician Stewardship of Health Care Resources
04 Amendment to E-11.2.1, Professionalism in Health Care Systems

CEJA Report(s)

05 Pandemic Ethics and the Duty of Care (D-130.960)
06 Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report

Report of the Speakers

01 Recommendations for Policy Reconciliation

REPORT OF THE BOARD TRUSTEES

B of T Report 3-A-22

Subject: 2021 Grants and Donations

Presented by: Bobby Mukkamala, MD, Chair

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

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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	23
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		**212**
Total Grants and Donations		**$ 2,220**

REPORT OF THE BOARD OF TRUSTEES

B of T Report 5-A-22

Subject: Update on Corporate Relationships

Presented by: Bobby Mukkamala, MD, Chair

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 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.

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Appendix A

CORPORATE REVIEW PROCESS OVERVIEW

The Corporate Review Team (CRT) includes senior managers from the following areas: Strategy, Finance, Health Solutions Group (HSG), Advocacy, Federation Relations, Office of the General Counsel, Medical Education, Publishing, Ethics, Enterprise Communications (EC), Marketing and Member Experience (MMX), Center for Health Equity, and Health and Science.

The CRT evaluates each project submitted to determine fit or conflict with AMA Corporate Guidelines, covering:

- Type, purpose and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA logo;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

The CRT reviews and makes recommendations regarding the following types of activities that utilize AMA name and logo:

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.

- AMA sponsorship of external events.

- Independent and company-sponsored foundation supported projects.

- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks. This does not include database or Current Procedural Terminology (CPT ®) licensing.)

- Member programs such as new affinity or insurance programs and member benefits.

- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.

- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.

- Collaboration with academic institutions 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

Project No.	Project Description	Corporations	Approval Date
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	2/8/2021

		American Association of Colleges of Osteopathic Medicine DoctorDale Agency LLC DiverseMedicine Inc.	
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)	6/22/2021

		TEGNA, Inc. McClatchy Amida Care	
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	**73rd 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 Akera 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) Wyncote The Washington Post Verizon Media Knight Knight Stanford Fox News Facebook FourBlock Scripps	8/27/2021
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 45th 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	9/23/2021

		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.	
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	9/30/2021

		Mercer NORC at University of Chicago Symphony Care, LLC	
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 American Medical Women's Association Association of Academy Physiatrists 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	10/5/2021

		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
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)	10/25/2021

		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	
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 Ximedica 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 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	2/8/2021
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'Conner 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 Novant Health, NC Mission Health, NC Atrium - The Charlotte-Mecklenburg Hospital	4/22/2021

		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 (Portand, 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	8/20/2021

		University of Utah Health	
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/HCPro	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.	11/16/2021

		Wisconsin Primary Health Care Association	
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 America's Health Insurance Plans Blue Cross Blue Shield Association Business Group on Health	12/9/2021
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

REPORT OF THE BOARD OF TRUSTEES

B of T Report 6-A-22

Subject: Redefining AMA's Position on ACA and Healthcare Reform

Presented by: Bobby Mukkamala, MD, Chair

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, "Redefining AMA's Position on ACA and Healthcare Reform," which called on our American Medical Association (AMA) to "develop a policy statement clearly outlining this organization's policies" on several specific issues related to the Affordable Care Act (ACA) as well as repealing the SGR and the Independent Payment Advisory Board (IPAB). The adopted policy went on to call for our AMA to report back at each meeting of the HOD. Board of Trustees Report 6-I-13, "Redefining AMA's Position on ACA and Healthcare Reform," accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

IMPROVING THE AFFORDABLE CARE ACT

Our AMA continues to engage policymakers and advocate for meaningful, affordable health care for all Americans to improve the health of our nation. Our AMA remains committed to the goal of universal coverage, which includes protecting coverage for the 20 million Americans who acquired it through the ACA. Our AMA has been working to fix the current system by advancing solutions that make coverage more affordable and expanding the system's reach to Americans who fall within its gaps. Our AMA also remains committed to improving health care access so that patients receive timely, high-quality care, preventive services, medications, and other necessary treatments.

Our AMA continues to advocate for policies that would allow patients and physicians to be able to choose from a range of public and private coverage options with the goal of providing coverage to all Americans. Specifically, our AMA has been working with Congress, the Administration, and states to advance our plan to cover the uninsured and improve affordability as included in the "2021 and Beyond: AMA's Plan to Cover the Uninsured." The COVID-19 pandemic has led to many people losing their employer-based health insurance. This has only increased the need for significant improvements to the Affordable Care Act. We also continue to examine the pros and cons of a broad array of approaches to achieve universal coverage as the policy debate evolves.

Our AMA has been advocating for the following policy provisions:

Cover Uninsured Eligible for ACA's Premium Tax Credits

- Our AMA advocates for increasing the generosity of premium tax credits to improve premium affordability and incentivize tax credit eligible individuals to get covered. Currently, eligible individuals and families with incomes between 100 and 400 percent federal poverty level (FPL) (133 and 400 percent in Medicaid expansion states) are being provided with refundable and advanceable premium tax credits to purchase coverage on health insurance exchanges.
- Our AMA has been advocating for enhanced premium tax credits to young adults. In order to improve insurance take-up rates among young adults and help balance the individual health

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insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium tax credits could be provided with "enhanced" premium tax credits—such as an additional $50 per month—while maintaining the current premium tax credit structure which is inversely related to income, as well as the current 3:1 age rating ratio.

- Our AMA also is advocating for an expansion of the eligibility for and increasing the size of cost-sharing reductions. Currently, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which leads to lower deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts. Extending eligibility for cost-sharing reductions beyond 250 percent FPL, and increasing the size of cost-sharing reductions, would lessen the cost-sharing burdens many individuals face, which impact their ability to access and afford the care they need.

<u>Cover Uninsured Eligible for Medicaid or Children's Health Insurance Program</u>

Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for Medicaid or 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.

<u>Make Coverage More Affordable for People Not Eligible for ACA's Premium Tax Credits</u>

Before the COVID-19 pandemic, in 2018, 5.7 million of the nonelderly uninsured were ineligible for financial assistance under the ACA, either due to their income, or because they have an offer of "affordable" employer-sponsored health insurance coverage. Without the assistance provided by ACA's premium tax credits, this population can continue to face unaffordable premiums and remain uninsured.

- Our AMA advocates for eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent FPL.
- Our AMA has been advocating for the establishment of a permanent federal reinsurance program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher premiums across the board in anticipation of higher-risk people enrolling in coverage. Section 1332 waivers have also been approved to provide funding for state reinsurance programs.
- Our AMA also is advocating for lowering the threshold that determines whether an employee's premium contribution is "affordable," allowing more employees to become eligible for premium tax credits to purchase marketplace coverage.

EXPAND MEDICAID TO COVER MORE PEOPLE

Before the COVID-19 pandemic, in 2018, 2.3 million of the nonelderly uninsured found themselves in the coverage gap—not eligible for Medicaid, and not eligible for tax credits because

they reside in states that did not expand Medicaid. Without access to Medicaid, these individuals do not have a pathway to affordable coverage.

- Our AMA has been encouraging all states to expand Medicaid eligibility to 133 percent FPL.

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.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 7-A-22

Subject: AMA Performance, Activities, and Status in 2021

Presented by: Bobby Mukkamala, MD, Chair

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

INTRODUCTION

The AMA's mission is to promote the art and science of medicine and the betterment of public health. As the physician organization whose reach and depth 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.

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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."

REPORT OF THE BOARD OF TRUSTEES

B of T Report 8-A-22

Subject: Annual Update on Activities and Progress in Tobacco Control: March 2021 through February 2022

Presented by: Bobby Mukkamala, MD, Chair

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.

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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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REPORT 10 OF THE BOARD OF TRUSTEES (A-22)
American Medical Association Center for Health Equity Annual Report
(Center for Health Equity Annual Report)
(Informational)

EXECUTIVE SUMMARY

Background: At the 2018 Annual Meeting, the House of Delegates adopted the recommendations of 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: The AMA has steadfastly enhanced efforts over recent years to further embed equity in our work. The Plan serves as a guide for this work. This report outlines the activities conducted by our AMA during calendar year 2021, divided into five (5) 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.

Conclusion: Despite challenges, including the ongoing COVID-19 pandemic, our AMA persevered in efforts to advance equity by continuously engaging in meaningful conversations, and finding innovative ways to connect, learn, and create. In 2021, it is estimated that our AMA mobilized at least 560 staff, collectively contributing more than 54,000 hours (or at least 30 full-time equivalents) to advance equity. The AMA continued to promote the art and science of medicine and the betterment of public health, advancing equity and embedding racial and social justice, making significant progress towards fulfilling the commitments outlined in the Plan during its first official year.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-A-22

Subject: American Medical Association Center for Health Equity Annual Report

Presented by: Bobby Mukkamala, MD, Chair

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

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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:

- 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

[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

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. 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 minoritized 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
4. Ensure equitable structures and opportunities in innovation	a. Embed equity within existing AMA health care innovation efforts		2	3	4	26	346
	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						
5. Foster truth and racial healing, reconciliation and transformation for the AMA's past	a. Amplify and integrate often "invisible-ized" narratives of historically marginalized physicians and patients in all that we do				4	4	240
	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	

REPORT 12 OF THE BOARD OF TRUSTEES (A-22)
DISAGGREGATION OF DEMOGRAPHIC DATA FOR INDIVIDUALS OF MIDDLE EASTERN AND NORTH AFRICAN (MENA) DESCENT
(Informational)

EXECUTIVE SUMMARY

This informational report is put forth in response to Policy D-350.979 "Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent," which directs our AMA to "(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."

This report lays out a historical overview of debates surrounding MENA as a separate category in race/ethnicity categorization and summarizes the current standing of these debates in the health equity research literature. Finally, this report outlines ways that our AMA can implement this directive, focusing on our initiatives to study data disaggregation by race/ethnicity.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-A-22

Subject: Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent

Presented by: Bobby Mukkamala, MD, Chair

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 Germine Awad et al note, the process reflects political motivations ranging from "remedying 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,

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[*] 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).

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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 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

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[†] 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.

(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):

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:

Figure 1: Three options for collecting MENA data

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, Abuelezam 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").

REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-A-22

Subject: Demographic Report of the House of Delegates and AMA Membership

Presented by: Bobby Mukkamala, MD, Chair

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

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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.

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 physician's 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

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 1-A-22

Subject: Amendment to E-1.1.6, "Quality"

Presented by: Alexander M. Rosenau, DO, Chair

INTRODUCTION

At the November 2021 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-N-21, "Amendments to Opinions 1.2.11, 'Ethical Innovation in Medical Practice'; 11.1.2, 'Physician Stewardship of Health Care Resources'; 11.2.1, 'Professionalism in Health Care Systems'; and 1.1.6, 'Quality.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-1.1.6, Quality

As professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable.

While responsibility for quality of care does not rest solely with physicians, their role is essential. Individually and collectively, physicians should actively engage in efforts to improve the quality of health care by:

(a) Keeping current with best care practices and maintaining professional competence.

(b) Holding themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.

(c) Using new technologies and innovations that have been demonstrated to improve patient outcomes and experience of care, in keeping with ethics guidance on innovation in clinical practice and stewardship of health care resources.

(d) Monitoring the quality of care they deliver as individual practitioners—e.g., through personal case review and critical self-reflection, peer review, and use of other quality improvement tools.

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(e) Demonstrating commitment to develop, implement, and disseminate appropriate, well-defined quality and performance improvement measures in their daily practice.

(f) Participating in educational, certification, and quality improvement activities that are well designed and consistent with the core values of the medical profession.

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 2-A-22

Subject: Amendment to E-1.2.11, "Ethical Innovation in Medical Practice"

Presented by: Alexander M. Rosenau, DO, Chair

INTRODUCTION

At the November 2021 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-N-21, "Amendments to Opinions 1.2.11, 'Ethical Innovation in Medical Practice'; 11.1.2, 'Physician Stewardship of Health Care Resources'; 11.2.1, 'Professionalism in Health Care Systems'; and 1.1.6, 'Quality.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-1.2.11, Ethically Sound Innovation in Clinical Practice

Innovation in medicine can span a wide range of activities. It encompasses not only improving an existing intervention, using an existing intervention in a novel way, or translating knowledge from one clinical context into another but also developing or implementing new technologies to enhance diagnosis, treatment, and health care operations. Innovation shares features with both research and patient care, but it is distinct from both.

When physicians participate in developing and disseminating innovative practices, they act in accord with professional responsibilities to advance medical knowledge, improve quality of care, and promote the well-being of individual patients and the larger community. Similarly, these responsibilities are honored when physicians enhance their own practices by expanding the range of tools, techniques, or interventions they employ in providing care.

Individually, physicians who are involved in designing, developing, disseminating, or adopting innovative modalities should:

(a) Innovate on the basis of sound scientific evidence and appropriate clinical expertise.

(b) Seek input from colleagues or other medical professionals in advance or as early as possible in the course of innovation.

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(c) Design innovations so as to minimize risks to individual patients and maximize the likelihood of application and benefit for populations of patients.

(d) Be sensitive to the cost implications of innovation.

(e) Be aware of influences that may drive the creation and adoption of innovative practices for reasons other than patient or public benefit.

When they offer existing innovative diagnostic or therapeutic services to individual patients, physicians must:

(f) Base recommendations on patients' medical needs.

(g) Refrain from offering such services until they have acquired appropriate knowledge and skills.

(h) Recognize that in this context informed decision making requires the physician to disclose:

(i) how a recommended diagnostic or therapeutic service differs from the standard therapeutic approach if one exists;

(ii) why the physician is recommending the innovative modality;

(iii) what the known or anticipated risks, benefits, and burdens of the recommended therapy and alternatives are;

(iv) what experience the professional community in general and the physician individually has had to date with the innovative therapy;

(v) what conflicts of interest the physician may have with respect to the recommended therapy.

(i) Discontinue any innovative therapies that are not benefiting the patient.

(j) Be transparent and share findings from their use of innovative therapies with peers in some manner. To promote patient safety and quality, physicians should share both immediate or delayed positive and negative outcomes.

To promote responsible innovation, health care institutions and the medical profession should:

(k) Ensure that innovative practices or technologies that are made available to physicians meet the highest standards for scientifically sound design and clinical value.

(l) Require that physicians who adopt innovations into their practice have relevant knowledge and skills.

(m) Provide meaningful professional oversight of innovation in patient care.

(n) Encourage physician-innovators to collect and share information about the resources needed to implement their innovations safely, effectively, and equitably.

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 3-A-22

Subject: Amendment to E-11.1.2, "Physician Stewardship of Health Care Resources"

Presented by: Alexander M. Rosenau, DO, Chair

INTRODUCTION

At the November 2021 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-N-21, "Amendments to Opinions 1.2.11, 'Ethical Innovation in Medical Practice'; 11.1.2, 'Physician Stewardship of Health Care Resources'; 11.2.1, 'Professionalism in Health Care Systems'; and 1.1.6, 'Quality.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-11.1.2, Physician Stewardship of Health Care Resources

Physicians' primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians' primary obligation to serve the interests of individual patients.

To fulfill their obligation to be prudent stewards of health care resources, physicians should:

(a) Base recommendations and decisions on patients' medical needs.

(b) Use scientifically grounded evidence to inform professional decisions when available.

(c) Help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals.

(d) Endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals.

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(e) Use technologies that have been demonstrated to meaningfully improve clinical outcomes to choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient but require different levels of resources.

(f) Be transparent about alternatives, including disclosing when resource constraints play a role in decision making.

(g) Participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile, which may include consulting other physicians, an ethics committee, or other appropriate resource.

Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession must create conditions for practice that make it feasible for individual physicians to be prudent stewards by:

(h) Encouraging health care administrators and organizations to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship.

(i) Advocating that health care organizations make available well-validated technologies to enhance diagnosis, treatment planning, and prognosis and support equitable, prudent use of health care resources.

(j) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect resource utilization and overall health care spending.

(k) Advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship.

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 4-A-22

Subject: Amendment to E-11.2.1, "Professionalism in Health Care Systems"

Presented by: Alexander M. Rosenau, DO, Chair

INTRODUCTION

At the November 2021 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-N-21, "Amendments to Opinions 1.2.11, 'Ethical Innovation in Medical Practice'; 11.1.2, 'Physician Stewardship of Health Care Resources'; 11.2.1, 'Professionalism in Health Care Systems'; and 1.1.6, 'Quality.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-11.2.1, Professionalism in Health Care Systems

> Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.
>
> Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.
>
> Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.
>
> Formularies, clinical practice guidelines, decision support tools that rely on augmented intelligence, and other mechanisms intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.
>
> Physicians in leadership positions within health care organizations and the profession should:

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(a) Ensure that decisions to implement practices or tools for organizing the delivery of care are transparent and reflect input from key stakeholders, including physicians and patients.

(b) Recognize that over reliance on financial incentives or other tools to influence clinical decision making may undermine physician professionalism.

(c) Ensure that all such tools:

(i) are designed in keeping with sound principles and solid scientific evidence.

a. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles.

b. Practice guidelines, formularies, and similar tools should be based on best available evidence and developed in keeping with ethics guidance.

c. Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated in relevantly similar populations of patients and care settings.

(ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;

(iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;

(iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.

(d) Encourage, rather than discourage, physicians (and others) to:

(i) provide care for patients with difficult to manage medical conditions;

(ii) practice at their full capacity, but not beyond.

(e) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.

(f) Ensure that the use of financial incentives and other tools is routinely monitored to:

(i) identify and address adverse consequences;

(ii) identify and encourage dissemination of positive outcomes.

All physicians should:

(g) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.

(h) Advocate for changes in how the delivery of care is organized to promote access to high-quality care for all patients.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 5-A-22

Subject: Pandemic Ethics and the Duty of Care (D-130.960)

Presented by: Alexander M. Rosenau, DO, Chair

Policy D-130.960, "Pandemic Ethics and the Duty of Care," adopted by the American Medical Association (AMA) House of Delegates in June 2021, asks the Council on Ethical and Judicial Affairs to "reconsider its guidance on pandemics, disaster response and preparedness in terms of the limits of professional duty of individual physicians, especially in light of the unique dangers posed to physicians, their families and colleagues during the COVID-19 global pandemic."

A CONTESTED DUTY

As several scholars have noted, the idea that physicians have a professional duty to treat has waxed and waned historically, at least in the context of infectious disease [1,2,3]. Many physicians fled the Black Death; those who remained did so out of religious devotion, or because they were enticed by remuneration from civic leaders [1]. Even in the early years of the AIDS epidemic, physicians contested whether they had a responsibility to put themselves at risk for what was then a lethal and poorly understood disease [3]. Yet the inaugural edition of the AMA *Code of Medical Ethics* in 1847 codified a clear expectation that physicians would accept risk:

> When pestilence prevails, it is [physicians'] duty to face the danger, and to continue their labors for the alleviation of suffering, even at the jeopardy of their own lives [1847 Code, p. 105].

That same sensibility informs AMA's Declaration of Professional Responsibility when it calls on physicians to "apply our knowledge and skills when needed, though it may put us at risk." And it is embedded in current guidance in the *Code*. Based on physicians' commitment of fidelity to patients, Opinion 8.3, "Physicians' Responsibilities in Disaster Response and Preparedness," enjoins a duty to treat. This opinion provides that "individual physicians have an obligation to provide urgent medical care during disasters . . . . even in the face of greater than usual risks to physicians' own safety, health, or life." The *Code* is clear that this obligation isn't absolute, however. Opinion 8.3 qualifies the responsibility when it notes that "physicians also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future."

From the perspective of the *Code*, then, the question isn't whether physicians have a duty to treat but how to think about the relative strength of that duty in varying circumstances.

INTERPRETING ETHICS GUIDANCE

Over the course of the COVID-19 pandemic, AMA has drawn on the *Code* to explore this question in reflections posted to its COVID-19 Resource Center on whether physicians may decline to treat unvaccinated patients and under what conditions medical students may ethically be permitted to graduate early to join the physician workforce.

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Drawing particularly on guidance in Opinion 1.1.2, "Prospective Patients," and—in keeping with Opinion 8.3, taking physicians' expertise and availability as itself a health care resource—Opinion 11.1.3, "Allocating Limited Health Care Resources," as well as Opinion 8.7, "Routine Universal Immunization of Physicians," these analyses offer key criteria for assessing the strength of the duty to treat:

- urgency of medical need
- risk to other patients or staff in a physician's practice
- risk to the physician
- likelihood of occurrence and magnitude of risk

To these criteria should be added likelihood of benefit—that is, physicians should not be obligated to put themselves at significant risk when patients are not likely to benefit from care [2]. Although the *Code* does not link the question specifically to situations of infectious disease or risk to physicians, it supports this position. Opinion 5.5, "Medically Ineffective Interventions," provides that physicians are not obligated to provide care that, in their considered professional judgment, will not provide the intended clinical benefit or achieve the patient's goals for care.

Similarly, to the extent that the *Code* articulates a general responsibility on the part of physicians to protect the well-being of patients and staff, it supports consideration of risk to others in assessing the relative strength of a duty to treat. Thus, while Opinion 1.1.2 explicitly prohibits physicians from declining a patient based solely on the individual's disease status, it permits them to decline to provide care to patients who threaten the well-being of other patients or staff. In the context of a serious, highly transmissible disease this responsibility to minimize risk to others in professional settings may constrain the presumption of a duty to treat.

Yet the *Code* is also silent on important matters that have been noted in the literature. For example, it doesn't address whether the duty to treat applies uniformly across all medical specialties. Some scholars argue that the obligation should be understood as conditioned by physicians' expertise, training, and role in the health care institution [4,5,6]. In essence, the argument is that the more relevant a physician's clinical expertise is to the needs of the moment, the more reasonable it is to expect physicians to accept greater personal risk than clinicians who don't have the same expertise. The point is well taken. Guidance that addresses the duty to treat "as if it were the exclusive province of any individual health profession" [2], risks undercutting its own value to offer insight into that duty.

Moreover, for the most part the *Code* restricts its analysis of physicians' responsibilities to the context of their professional lives, addressing their duties to patients, and to a lesser degree, to their immediate colleagues in health care settings. In this, guidance overlooks the implications of responsibilities physicians hold in their *nonprofessiona*l lives—as members of families, as friends, as participants in community outside the professional domain. Thus, it is argued, a physician whose household includes a particularly vulnerable individual—e.g., someone who has chronic underlying medical condition or is immune compromised and thus at high risk for severe disease—has a less stringent duty to treat than does a physician whose personal situation is different.

Although the *Code* acknowledges that physicians indeed have lives as moral agents outside medicine (Opinion 1.1.7, "Physician Exercise of Conscience"), it does not reflect as deeply as it might about the nature of competing personal obligations or how to balance the professional and the personal. In much the same way as understanding the duty to treat as the responsibility of a single profession, restricting analysis to a tension between altruism and physicians' individual self-

interest "fails to capture the real moral dilemmas faced by health care workers in an infectious epidemic" [7].

SUPPORTING THE HEALTH CARE WORKFORCE

As adopted in 1847, the *Code* addressed physicians' ethical obligations in the broader framework of reciprocal obligations among medical professionals, patients, and society. Over time, the *Code* came to focus primarily on physician conduct.

Pandemic disease doesn't respect conceptual boundaries between the professional and the personal, the individual and the institutional. Nor does it respect the borders of communities or catchment areas. In situations of pandemic disease, "the question is one of a social distribution of a biologically given risk within the workplace and society at large" [7].

Health Care Institutions

Under such conditions, it is argued, the duty to treat "is not to be borne solely by the altruism and heroism of individual health care workers" [7]. Moreover, as has been noted,

> … organizations, as well as individuals, can be virtuous. A virtuous organization encourages and nurtures the virtuous behavior of the individuals within it. At the very least, the virtuous institution avoids creating unnecessary barriers to the virtuous behavior of individuals [2].

The *Code* is not entirely insensitive to the ethics of health care institutions. It touches on institutions' responsibility to the communities they serve (Opinion 11.2.6, "Mergers between Secular and Religiously Affiliated Health Care Institutions"), and to the needs of physicians and other health care personnel who staff them (Opinions 11.1.2, "Physician Stewardship of Health Care Resources," and 11.2.1, "Professionalism in Health Care Systems). Health care facilities and institutions are the locus within which the practice of today's complex health care takes place. As such, institutions—notably nonprofit institutions—too have duties,

> … fidelity to patients, service to patients, ensuring that the care is high quality and provided "in an effective and ethically appropriate manner"; service to the community the hospital serves, deploying hospital resources "in ways that enhance the health and quality of life" of the community; and institutional stewardship [CEJA 2-A-18].

Analyses posted to the AMA's COVID-19 Resource Center look to this guidance to examine institutional obligations to protect health care personnel and to respect physicians who voice concern when institutional policies and practices impinge on clinicians' ability to fulfill their ethical duties as health care professionals.

Although existing guidance does not explicitly set out institutional responsibility to provide appropriate resources and strategies to mitigate risk for health care personnel, it does support such a duty. The obligation to be responsible stewards of resources falls on health care institutions as well as individuals. To the extent that health care professionals themselves are an essential and irreplaceable resource for meeting patient and community needs, institutions have an ethical duty to protect the workforce (independent of occupational health and safety regulation). On this view, institutions discharge their obligations to the workforce when, for example, they

- support robust patient safety and infection control practices
- make immunization readily available to health care personnel

- provide adequate supplies of appropriate personal protective equipment (PPE)
- ensure that staffing patterns take into account the toll that patient care can exact on frontline clinicians
- distribute burdens equitably among providers in situations when individual physicians or other health care personnel *should not* put themselves at risk
- have in place fair and transparent mechanisms for responding to individuals who decline to treat on the basis of risk. (Compare Opinion 8.7, "Routine Universal Immunization of Physicians.")

Equally, institutions support staff by gratefully acknowledging the contributions all personnel make to the operation of the institution and providing psychosocial support for staff.

Professional Organizations

So too physicians and other health care professionals should be able to rely on their professional organizations to advocate for appropriate support of the health care workforce, as in fact several organizations have done over the course of the COVID-19 pandemic. In March 2020, the American Medical Association, American Hospital Association, and American Nurses Association, for example, jointly argued vigorously for and helped secure use of the Defense Production Act (DPA) to provide PPE. The American College of Physicians similarly urged use of the DPA to address the shortage of PPE. Physicians for Human Rights led a coalition of organizations that called on the National Governors Association to urge governors to implement mandatory standards for protecting health workers during the pandemic.

The AMA further advocated for opening visa processing for international physicians to help address workforce issues, and secured financial support for physician practices under the Provider Relief Fund of the American Rescue Plan Act.

Public Policy

As noted, the *Code* originally delineated reciprocal obligations among physicians, patients, and society. Such obligations on the part of communities and public policymakers should be acknowledged as among the main factors that "contour the duty to treat" [1]. More specifically, it is argued,

> in preparation for epidemics communities should: 1) take all reasonable precautions to prevent illness among health care workers and their families; 2) provide for the care of those who do become ill; 3) reduce or eliminate malpractice threats for those working in high-risk emergency situations; and 4) provide reliable compensation for the families of those who die while fulfilling this duty [1].

In the face of the failure on the part of health care institutions and public agencies to ensure that essential resources have been in place to reduce risk and lessen the burdens for individuals of taking on the inevitable risk that remains, it is understandable that physicians and other health care professionals may resent the expectation that they will unhesitatingly put themselves at risk. At least one scholar has forcefully argued that, in the case of COVID-19, celebrations of medical heroism were overwhelmingly insensitive to the fact such heroism was the "direct, avoidable consequence" of institutional and public policy decisions that left the health care system unprepared and transferred the burden of responding to the pandemic to individual health care professionals [8].

ACKNOWLEDGING THE DUTY TO TREAT: SOLIDARITY

In the end, seeing the duty to treat as simply a matter of physicians' altruistic dedication to patients forecloses considerations that can rightly condition the duty in individual circumstances. As Opinion 8.3 observes, providing care for individual patients in immediate need is not physicians only obligation in a public health crisis. They equally have an obligation to be part of ensuring that care can be provided in the future. Equating duty to treat with altruism "makes invisible moral conflicts between the various parties to whom a person may owe care, and interferes with the need of healthcare professionals to understand that they must take all possible measures consistent with the social need for a functioning healthcare system to protect themselves in an epidemic" [7].

Further, such a view not only elides institutional and societal obligations but misrepresents how the duty actually plays out in contemporary health care settings. The risks posed by pandemic disease are distributed across the health care workforce, not uniquely borne by individuals, let alone by individual physicians. Ultimately, the risk refused by one will be borne by someone else, someone who is more often than not a colleague [2,7]. From this perspective, accepting the duty to treat is an obligation physicians owe to fellow health care personnel as much as to patients or to society.

AN ENDURING PROFESSIONAL RESPONSIBILITY

Taken together, the foregoing considerations argue that physicians indeed *should* recognize the duty to treat as a fundamental obligation of professional ethics. This is not to argue that the duty is absolute and unconditional. However, as the Preface to Opinions of the Council on Ethical and Judicial Affairs observes, recognizing when circumstances argue against adhering to the letter of one's ethical obligations

> … requires physicians to use skills of ethical discernment and reflection. Physicians are expected to have compelling reasons to deviate from guidance when, in their best judgment, they determine it is ethically appropriate or even necessary to do so.

Decisions to decline a duty to treat during a public health crisis carry consequences well beyond the immediate needs of individual patients. In exercising the required discernment and ethical reflection, physicians should take into account:

- the urgency of patients' medical need and likelihood of benefit
- the nature and magnitude of risks to the physician and others to whom the physician also owes duties of care
- the resources available or reasonably attainable to mitigate risk to patients, themselves and others
- other strategies that could reasonably be implemented to reduce risk, especially for those who are most vulnerable
- the burden declining to treat will impose on fellow health care workers

Physicians who themselves have underlying medical conditions that put them at high risk for severe disease that cannot reasonably be mitigated, or whose practices routinely treat patients at high risk, have a responsibility to protect themselves as well as their patients. But protecting oneself and one's patients carries with it a responsibility to identify and act on opportunities to support colleagues who take on the risk of providing frontline care.

Physicians and other health care workers *should* be able to rely on the institutions within which they work to uphold the organization's responsibility to promote conditions that enable caregivers

to meet the ethical requirements of their professions. So too, physicians and other health care workers *should* be able to trust that public policymakers will make and enforce well-considered decisions to support public health and the health care workforce. When those expectations are not met, physicians have a responsibility to advocate for change [Principles III, IX].

Yet, grounded as it is in physicians' commitment of fidelity to patients, the professional duty to treat ultimately overrides the failure of institutions or society.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 6-A-22

Subject: Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

Presented by: Alexander M. Rosenau, DO, Chair

At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a detailed explanation of its judicial function. This undertaking was motivated in part by the considerable attention professionalism has received in many areas of medicine, including the concept of professional self-regulation.

CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove a membership application or to take action against a member. The disciplinary process begins when a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an applicant or member is reported to the AMA. This information most often comes from statements made in the membership application form, a report of disciplinary action taken by state licensing authorities or other membership organizations, or a report of action taken by a government tribunal.

The Council rarely re-examines determinations of liability or sanctions imposed by other entities. However, it also does not impose its own sanctions without first offering a hearing to the physician. CEJA can impose the following sanctions: applicants can be accepted into membership without any condition, placed under monitoring, or placed on probation. They also may be accepted, but be the object of an admonishment, a reprimand, or censure. In some cases, their application can be rejected. Existing members similarly may be placed under monitoring or on probation, and can be admonished, reprimanded or censured. Additionally, their membership may be suspended or they may be expelled. Updated rules for review of membership can be found at https://www.ama-assn.org/governing-rules.

Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA's activities during the most recent reporting period is presented.

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APPENDIX

CEJA
Judicial Function
Statistics

APRIL 1, 2021 – MARCH 31, 2022

Physicians Reviewed	SUMMARY OF CEJA ACTIVITIES
2	Determinations of no probable cause
27	Determinations following a plenary hearing
14	Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing

Physicians Reviewed	FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS
4	No sanction or other type of action
2	Monitoring
11	Probation
5	Revocation
5	Suspension
0	Denied
0	Suspension lifted
1	Censure
7	Reprimand
8	Admonish

Physicians Reviewed	PROBATION/MONITORING STATUS
13	Members placed on Probation/Monitoring during reporting interval
10	Members placed on Probation without reporting to Data Bank
6	Probation/Monitoring concluded satisfactorily during reporting interval
0	Memberships suspended due to non-compliance with the terms of probation
8	Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues
5	Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues

REPORT OF THE SPEAKERS

Speakers' Report 01-A-22

Subject: Recommendations for Policy Reconciliation

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

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Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," calls on your Speakers to "present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete."

Your Speakers present this report to deal with policies, or portions of policies, that are no longer relevant or that were affected by actions taken at recent meetings of the House of Delegates. Suggestions on other policy statements that your Speakers might address should be sent to hod@ama-assn.org for possible action. Where changes to policy language will be made, additions are shown with underscore and deletions are shown with strikethrough, 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

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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 "<u>AMA Resources, Advocacy, and Leadership Efforts to Secure Labor Protections for Physicians in Training</u>."

  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.

Fiscal Note: $50 to edit PolicyFinder