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** contained in the Handbook Addendum*

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

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- 1 The Consolidated Financial Statements for the years ended December 31, 2021 and 2020 and the
 - 2 Independent Auditor's report have been included in a separate booklet, titled "2021 Annual
 - 3 Report." This booklet is included in the Handbook mailing to members of the House of Delegates
 - 4 and will be discussed at the Reference Committee F hearing.



SUPPORTING PHYSICIANS. STRENGTHENING THEIR VOICE.



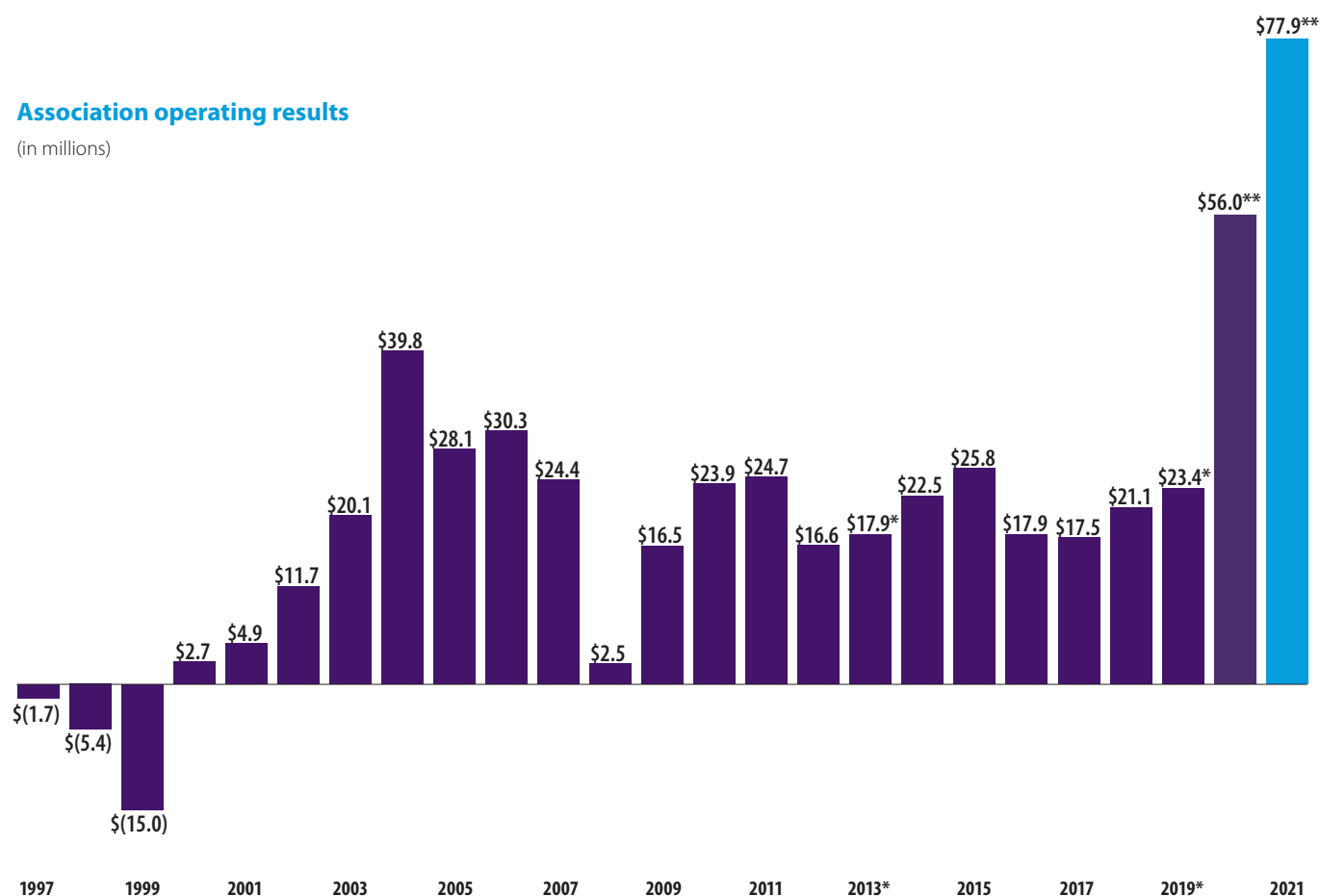
ANNUAL REPORT
2021

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.

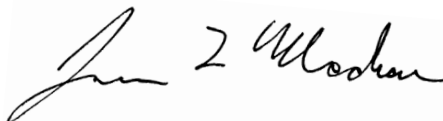
For all that has changed in health care and in our world during this pandemic, the AMA remains more committed than ever to elevating the physician voice, advancing equity, and embracing our mission to promote the art and science of medicine and the betterment of public health.



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.

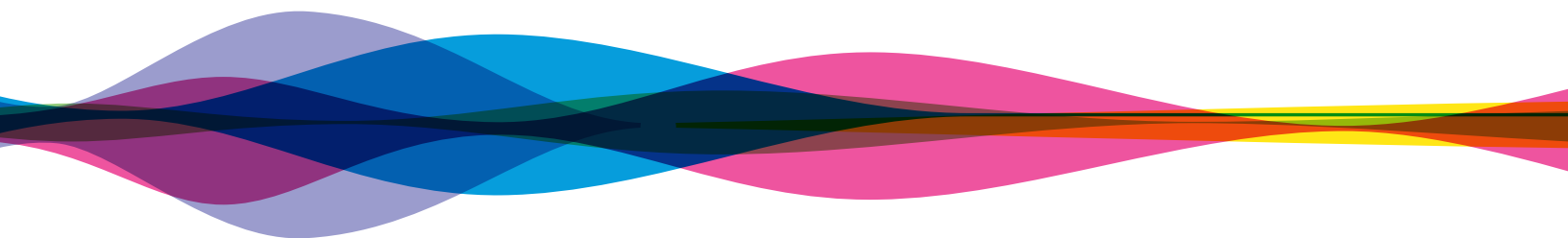
The AMA's yearslong effort to reinvent medical school education across the continuum supported student and resident training in health systems science, telehealth and improvements in the transition from medical school to residency. ChangeMedEd21 drew record attendance, highlighted by the "Bright Ideas 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.

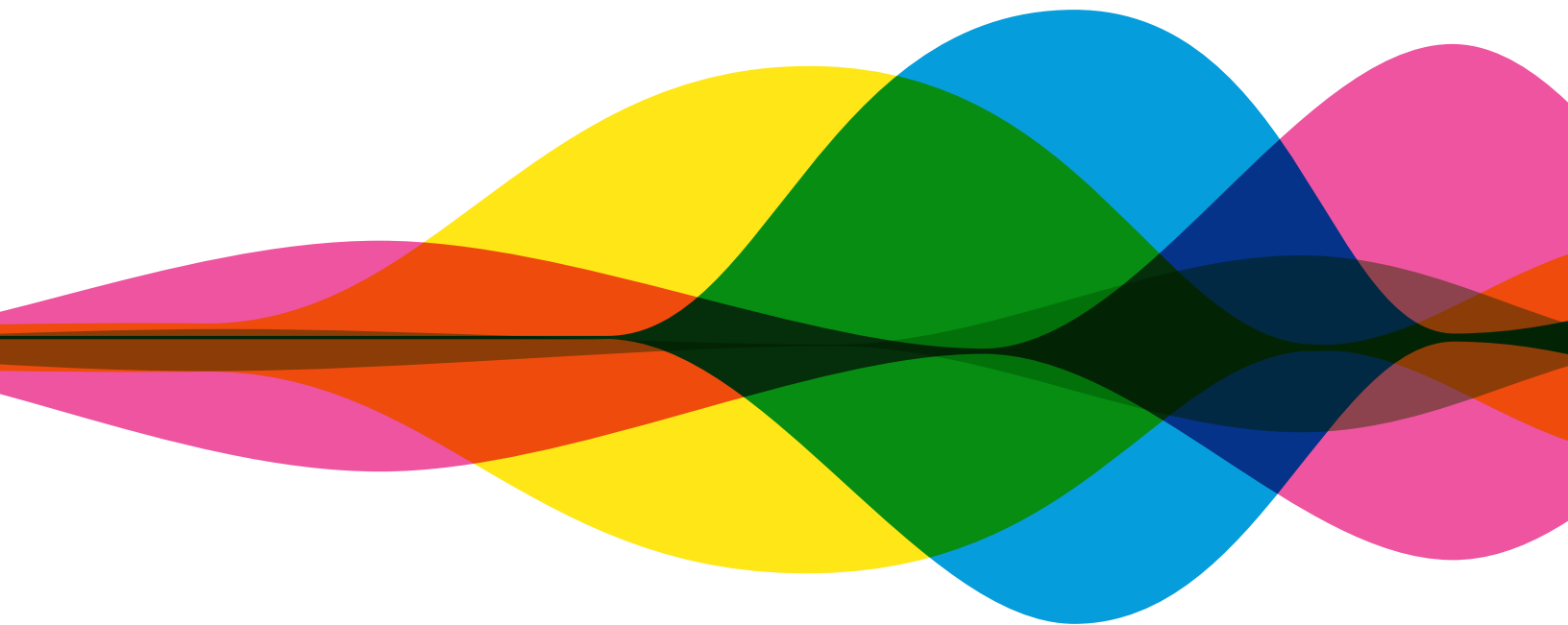


“We are the ones on the frontline and know firsthand the impact misinformation can [have]. Promote accurate and positive information ... you never know whose life you may change.”

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.

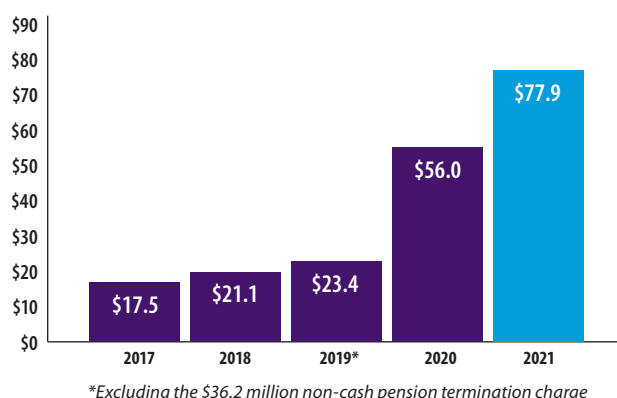
2021 saw great progress on many important activities, including the expansion of AMA's Center for Health Equity, with development of a three year enterprise equity action plan and an internal health equity training curriculum helping to embed health equity in all the work of AMA; continuation of AMA's 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)



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.

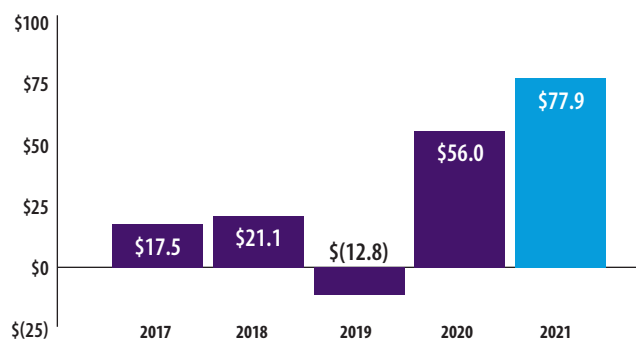
The following pages discuss the 2021 consolidated results from operations, financial position and cash flows, as compared to 2020. Additional detailed discussion of operating unit results is included in the section titled "Group Operating Results."

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.

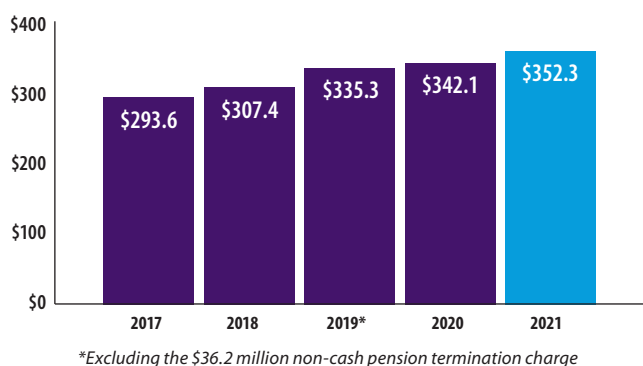
Contribution to general and administrative expenses

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)



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.

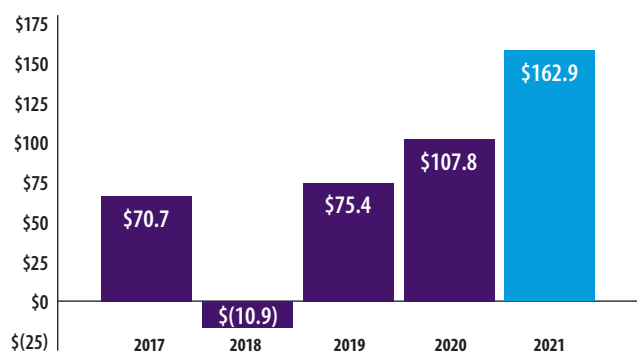
Revenue in excess of (less than) expenses

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.

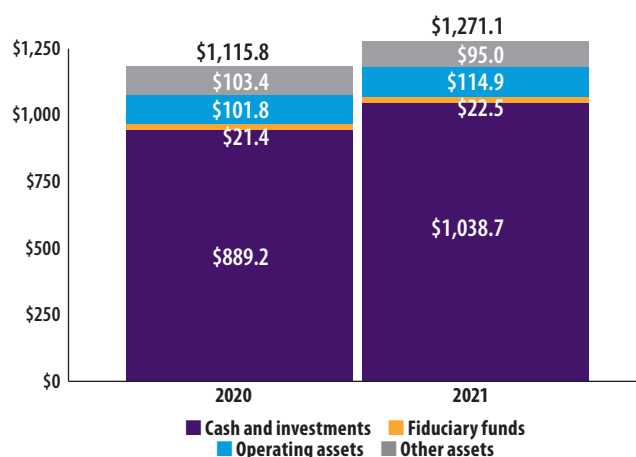
The AMA reported a \$107.8 million increase in association equity in 2020. This reflects the amount by which revenues exceeded expenses, less the charge to equity for changes in defined benefit postretirement plans discussed above, as well as a \$1.5 million decrease in donor-restricted equity due to 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.

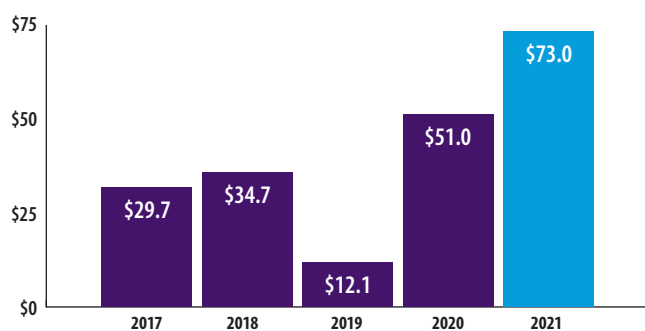
Deferred revenue represents funds received during the year that will not be recognized as income until the following year or thereafter. These amounts vary, as well as accounts payable and accrued expenses, depending on the timing of cash receipts and payments.

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)



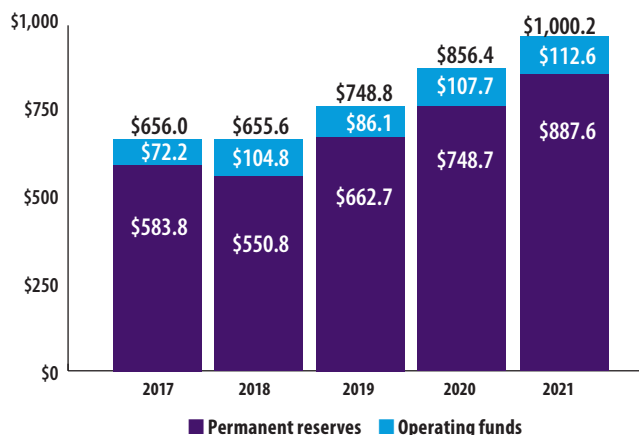
Free cash flow measures the AMA's ability to fund operations, capital expenses and major programmatic initiatives from funds generated from operations. This measure excludes non-operating gains and losses.

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.

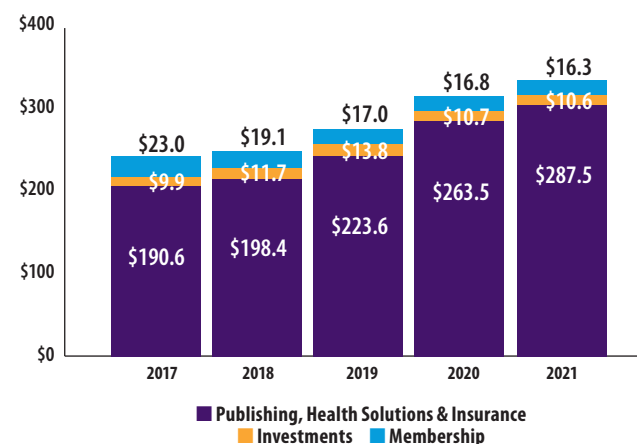
Contribution margin (net expenses)

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.

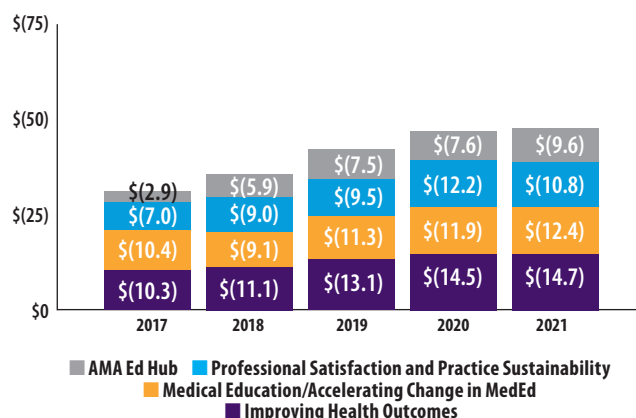
Investments' revenue was \$11.3 million in 2021, a \$0.1 million decrease over the prior year. Dividend and interest income improved in 2021 but was offset by higher management fees due to the growth in the portfolio value. The contribution margin declined by \$0.1 million as well.

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.

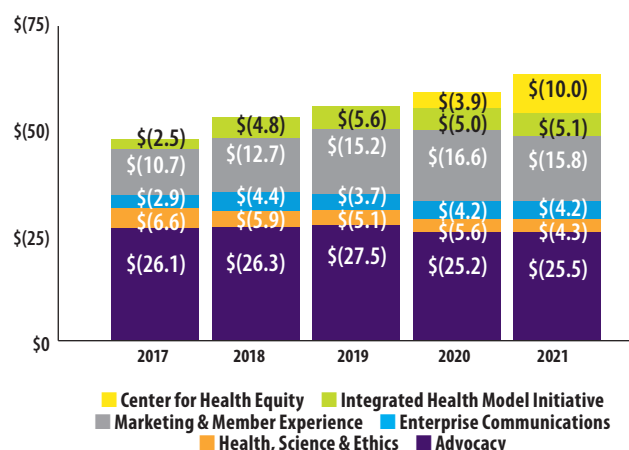
PS2 includes three major streams of work: professional satisfaction/practice transformation, practice sustainability, and digital health, all designed to improve the day-to-day practice and professional experience of physicians and remove obstacles to care.

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.

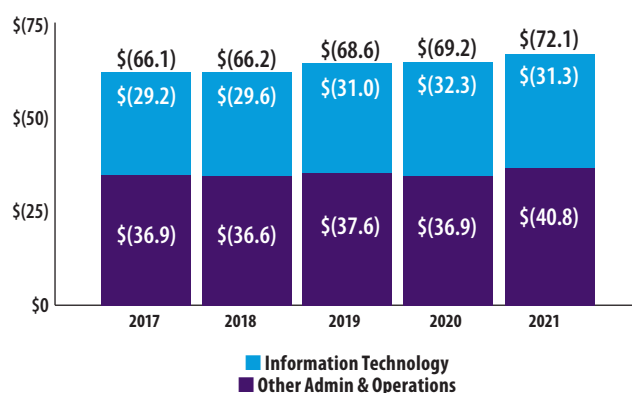
Ongoing responsibilities of the Enterprise Communications area include amplifying the work of individual operating units among their core audiences while providing consistency and alignment with the AMA narrative. Enterprise Communications distinctly communicates AMA's leading voice in science and evidence 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.

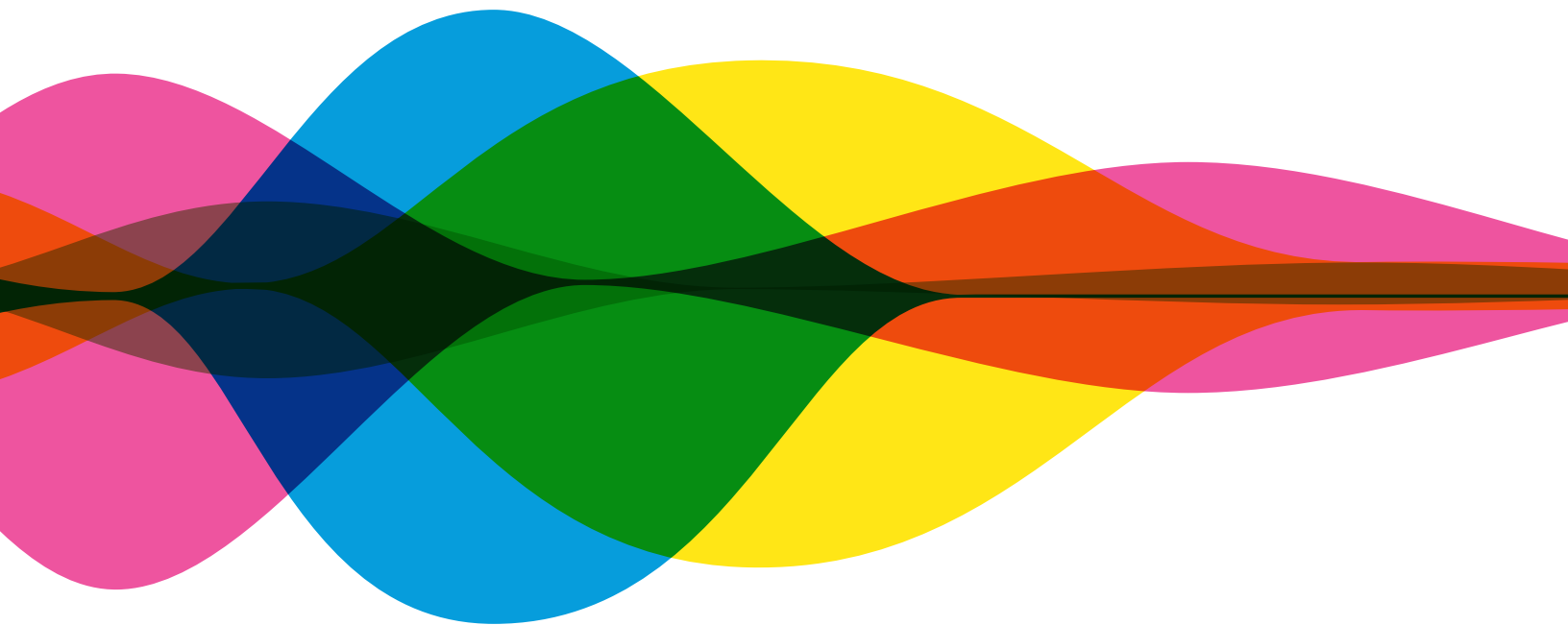
Health2047 revenue in 2021 was \$1 million, compared to \$2.3 million in 2020. In 2020, Health2047 recognized revenue and associated costs for creating custom applications for a customer, with revenue of \$2.6 million. Health2047 reflects its proportionate loss in earnings of affiliates as a contra revenue, 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		Margin (expenses)	
	2021	2020	2021	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

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.

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.

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	Health ²⁰⁴⁷ 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.

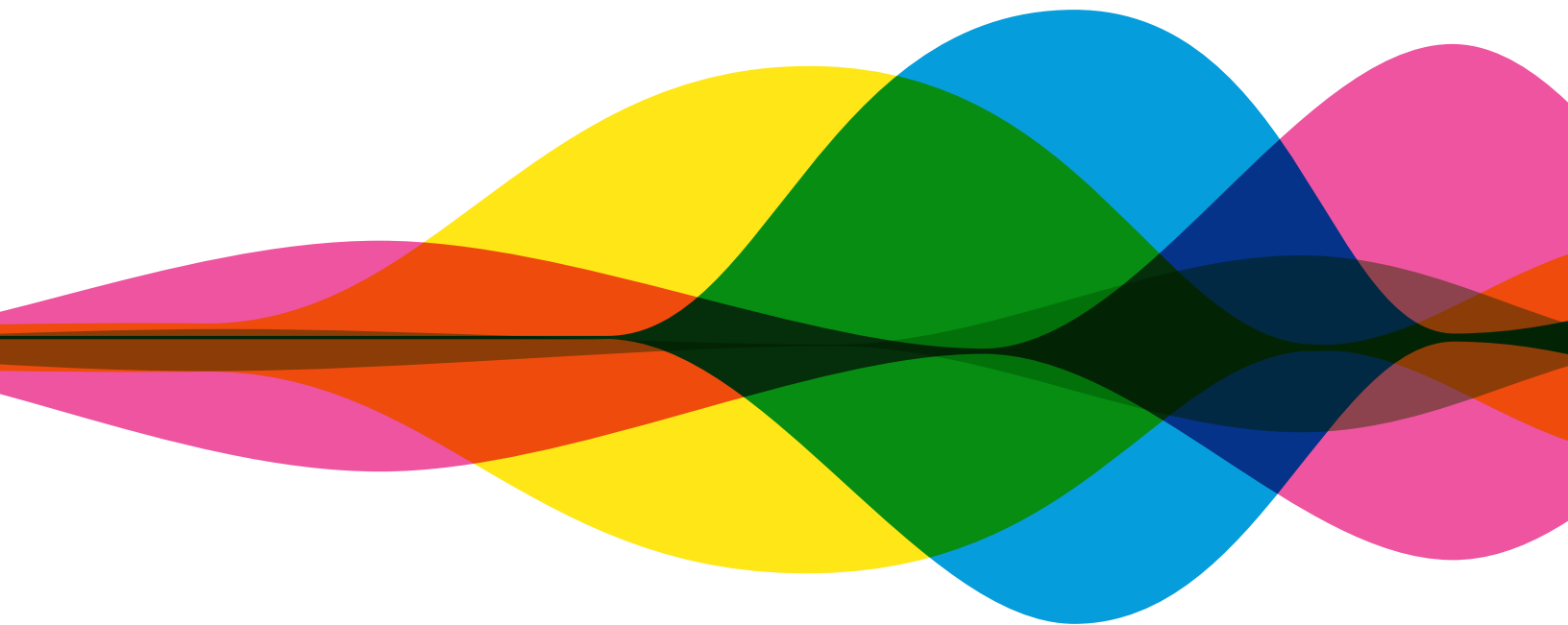
James L. Madara, MD

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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Thomas J. Madejski, MD

Mario E. Motta, MD

Harris Pastides, PhD, MPH

Michael Suk, MD, JD, MPH, MBA

Willie Underwood III, MD, MSc, MPH

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James L. Madara, MD
CEO and Executive Vice President

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Dr. Butler

Dr. Edwards

Dr. Motta

Dr. Pastides

Dr. Suk

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Dr. Levin

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Dr. Fryhofer (*ex-officio w/vote*)

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Dr. Suk

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Dr. Mukkamala

Dr. Resneck

Dr. Suk

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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Harris Pastides, PhD, MPH



Michael Suk, MD,
JD, MPH, MBA



Willie Underwood III, MD,
MSc, MPH



James L. Madara, MD



REPORT OF THE BOARD OF TRUSTEES

B of T Report 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.

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

1 description of each section and an overarching description of the sections (AMA Bylaws 7.0.1-
2 7.0.9), which vested in the Board the responsibility to review the rules, regulations, and procedures
3 adopted by each section (i.e., IOPs). Notably, these revisions did not eliminate bylaws provisions
4 fixing the size and core composition of the seven AMA Councils, which therefore remain to this
5 day the province of the House of Delegates.

6
7 While not addressed in the body of the CCB report, the impetus for moving section-related detail
8 from the bylaws to IOPs was to remove the burden on the House of Delegates of constant review
9 and approval of internal section matters—for example, election rules, policymaking procedures,
10 etc. It is not clear whether CCB, the House of Delegates, or the sections explicitly contemplated
11 whether the size and composition of a section governing council ought to be subject to review by
12 the House of Delegates, or whether this detail was simply swept from the bylaws along with other
13 details in a very long CCB recommendation.

14 15 DISCUSSION

16
17 Your Board believes that the size and at least some detail about the composition of section
18 governing councils should be subject to review and approval by the House of Delegates. Such
19 provisions are a critical piece of the AMA governance framework, and their current positioning
20 under the authority of the Board seems an anomaly compared to other oversight of the sections. In
21 particular, the House of Delegates is responsible for establishing new sections, and for renewing
22 section status for delineated sections, via a review facilitated by the Council on Long Range
23 Planning and Development (CLRPD). In the case of both a new section and renewal of delineated
24 status for an existing section, this review specifically examines whether “the structure of the group
25 [is] consistent with its objectives and activities” (AMA Policy G-615.001). The Board’s current
26 oversight of the size and composition of section governing councils is also an anomaly compared to
27 oversight of other AMA governance groups. Specifically, as noted above, the House of Delegates
28 has the sole authority to change the size and core composition of AMA Councils.

29
30 Your Board recognizes the wisdom of not codifying every section governance detail in the bylaws,
31 fearing that such action would require the House of Delegates to expend inordinate effort on
32 discussion of section governance revisions. We also recognize the need for flexibility and
33 timeliness as sections seek to revise peripheral aspects of their governance to streamline their
34 operations and thereby augment their impact. For these reasons, your Board proposes a middle-
35 ground solution in which the House of Delegates would reclaim authority to approve revisions with
36 fiscal impact (e.g., adding a member) or that alter core governing council membership (i.e., chair
37 cycle, delegate/alternate delegate), while the Board would retain authority to approve alterations to
38 non-core governing council positions (e.g., transforming a member at-large position into a vice
39 speaker position). This transfer of authority would be accomplished by amending the bylaws to
40 include the current size and core composition of each section governing council, making any future
41 changes in these areas subject to House of Delegates approval. Additionally, given the complexity
42 of these governance matters and CLRPD’s existing oversight of the sections, your Board
43 recommends that CLRPD play a central role in developing criteria for the consideration of and
44 reviewing future requests to alter the size or core composition of section governing councils.

1 RECOMMENDATION

2

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

5

6 1. That AMA Bylaws be amended to include the size and core composition (chair cycle,
7 delegate/alternate delegate) of each section governing council. (Modify Bylaws)

8

9 2. That the Council on Long Range Planning and Development develop criteria for reviewing
10 requests to alter the size or core composition (chair cycle, delegate/alternate delegate) of
11 section governing councils. (Directive to Take Action)

12

13 3. That the Council on Long Range Planning and Development be assigned responsibility for
14 reviewing and making recommendations to the House of Delegates as to the disposition of any
15 request to alter the size or core composition (chair cycle, delegate/alternate delegate) of a
16 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

professional interests in foreign language use in work-related contexts. The US Department of Health and Human Services is just one of the regularly attending ILR entities.

American Council on the Teaching of Foreign Languages Proficiency Scale - In the 1980s, the American Council on the Teaching of Foreign Languages (ACTFL) developed a proficiency scale for academic use and based it on the ILR proficiency scale. The ACTFL proficiency scale has five levels: novice, intermediate, advanced, superior, and distinguished. All but the superior and distinguished levels are made up of three sublevels: low, mid, and high. Although the ACTFL scale is the standard measure of proficiency in academia, it is also used by industry.

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

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

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

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

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

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

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

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

In 2010, the research team continued its study of the adapted scale focusing on the accuracy of self-assessment using the adapted ILR scale. The team concluded: "Self-assessment of non-English-language proficiency using the ILR correlates to tested language proficiency, particularly on the low and high ends of the scale. Participants who self-assess in the middle of the scale may require

additional testing. Further research needs to be conducted to identify the characteristics of primary care providers (PCP) whose self-assessments are inaccurate and, thus, require proficiency testing.”³

CURRENT COLLECTION OF LANGUAGE-RELATED DATA BY OUR AMA

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

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

It should also be noted that AMA Health Solutions, in collaboration with Medical Education and Health Equity, is working with an industry collaborative group around the collection, maintenance, and use of data to inform work specifically around workforce research and trends and health equity. The categorization and collection of language proficiency information has been identified as an area of interest and is currently scheduled for discussion in 2022. Initial participants include representatives from the Association of American Medical Colleges (AAMC) and Accreditation Council for Graduate Medical Education (ACGME). The collaborative has recently agreed upon categorization and values for race and ethnicity and is currently discussing sexual orientation and gender identity before turning attention to language proficiency.

COLLECTION OF LANGUAGE-RELATED DATA OUTSIDE OF OUR AMA

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

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

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

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

The Medical Board of California conducts a physician survey⁵ of allopathic physicians and surgeons at the time of license renewal. The goal of the mandated survey is to better understand California’s physician workforce. Among other things, the survey questions licensees about their

foreign language fluency; a response is voluntary. With this data, the Medical Board of California publishes an annual report about languages spoken (not proficiency) as segmented by county. The report is accessible via the HealthData.gov site.⁶

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

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

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

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

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

DISCUSSION

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

AMA POLICY

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

1 SUMMARY

2
3 The collection of this information is directly related to the work of the AMA's Center for Health
4 Equity. As such, this work should not be done in isolation and instead should be informed by the
5 overall strategy and work of the center. A scan of the market shows that while some organizations
6 are collecting information on languages spoken, most are lacking a meaningful proficiency
7 measurement and are collecting data at a specific point in time without a clear path to update the
8 data over time. Most notably, the AAMC is collecting information as part of the medical school
9 application process. This allows them to collect data on a large scale—all medical school
10 applicants—but does not afford them the ability to update this information throughout a physician's
11 career.

12
13 The industry would benefit from agreement on the appropriate data collection methods, values, and
14 scale. The AMA, AAMC and ACGME have formed an industry collaborative to discuss the
15 collection, maintenance, and access to data that will inform improvements in health equity and
16 workforce analysis. Language proficiency has been identified as an area of interest and is current
17 scheduled to be discussed in 2022.

18
19 RECOMMENDATIONS

20
21 In lieu of Resolution 613-A-19, it is recommended that our AMA continue its work with other
22 industry stakeholders to identify best practices, including adoption of a national standard, for the
23 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.
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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
<p>4: Advanced Professional Proficiency Able to use the language fluently and accurately on all levels normally pertinent to professional needs. The individual's language usage and ability to function are fully successful. Organizes discourse well, using appropriate rhetorical speech devices, native cultural references and understanding. Language ability only rarely hinders him/her in performing any task requiring language; yet, the individual would seldom be perceived as a native. Speaks effortlessly and smoothly and is able to use the language with a high degree of effectiveness, reliability and precision for all representational purposes within the range of personal and professional experience and scope of responsibilities. Can serve as an informal interpreter in a range of unpredictable circumstances. Can perform extensive, sophisticated language tasks, encompassing most matters of interest to well-educated native speakers, including tasks which do not bear directly on a professional specialty.</p>	<p>Very Good Able to use the language fluently and accurately on all levels related to work needs in a healthcare setting. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech. Language ability only rarely hinders him/her in performing at task requiring language; yet, the individual would seldom be perceived as a native.</p>	<p>Advanced I speak very accurately, and I understand other speakers very accurately. Native speakers have no problem understanding me, but they probably perceive that I am not a native speaker.</p>
<p>5: Functionally Native Proficiency Speaking proficiency is functionally equivalent to that of a highly articulate well-educated native speaker and reflects the cultural standards of the country where the language is natively spoken. The individual uses the language with complete flexibility and intuition, so that speech on all levels is fully accepted by well-educated native speakers in all of its features, including breadth of vocabulary and idiom, colloquialisms and pertinent cultural references. Pronunciation is typically consistent with that of well-educated native speakers of a non-stigmatized dialect.</p>	<p>Excellent Speaks proficiently, equivalent to that of an educated speaker, and is skilled at incorporating appropriate medical terminology and concepts into communication. Has complete fluency in the language such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural references.</p>	<p>Native/Functionally Native I converse easily and accurately in all types of situations. Native speakers may think that I am a native speaker, too.</p>

APPENDIX B – RELATED AMA POLICIES AND STANDARDS

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

considerably smaller, because of the anomalous nature of counting pending members. As outlined in the apportionment memoranda earlier this year, the timing of a member's payment affects whether that individual is counted for apportionment purposes. The pending member whose dues are received in Year 1 to become a member in Year 2 but whose dues for Year 3 are received after January 1 of Year 3 cannot be counted for apportionment purposes under the bylaws regarding pending members and apportionment. The following chart may be clearer:

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

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

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

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

Year [†]	Official 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.)

1 Since that initial round, tallying pending members has had no obvious impact, meaning the
 2 increase was essentially a one-time occurrence. This is so because at the end of 2019 pending
 3 members augmented the usual apportionment pool of active members. In the second and third years
 4 of this experiment, the number of pending members each year has been offset by the loss of
 5 members choosing not to renew their memberships. In essence, the group referred to as pending
 6 members comes from the same population that drops memberships. That is, these are physicians or
 7 students whose allegiance to or participation in the AMA varies over time, depending on factors
 8 such as current finances, recent advocacy matters, or even just whims. Add the timing of
 9 membership processing—before or after January 1—and the effect of including pending members
 10 in delegate apportionment is minimal, and possibly negative, after the first year.

11
 12 Surveys have for many years found that AMA advocacy is the most sought after and valued benefit
 13 of AMA membership. Aside from a handful of members who are seeking to become delegates, the
 14 notion that counting pending members for apportionment purposes will benefit physicians simply
 15 does not square with what members report. As a practical matter, benefits from our AMA's
 16 advocacy activities arguably accrue to all physicians, not just members, so the pending members
 17 gain little from that status. The onetime increase in delegation sizes combined with the
 18 complications of membership accounting do not warrant continuing the experiment. Rather a return
 19 to the historical practice of counting actual members for apportionment purposes—a practice that
 20 likely antedates the decision of all members of the House to become physicians—seems
 21 warranted.¹

22 23 AFTER THE EXPERIMENT

24
 25 Somewhat counterintuitively, absent the current freeze, counting pending members may have
 26 negatively affected nearly as many states as it helped, and while several states did gain delegates
 27 with the inclusion of pending members, only three states gained more than one delegate: two states
 28 gained two seats and one state gained 10 seats.

29
 30 Worth noting is the fact that the effect of the delegate freeze would have been limited for the 2021
 31 and 2022 apportionment years had the usual year-end count of AMA members been employed. The
 32 freeze was implemented based on fears that COVID-19 would adversely affect AMA membership
 33 and was adopted pursuant to Resolution 8-N-20, but AMA membership is up over the last two
 34 years, to 277,823 at the end of 2021 from 256,364 two years earlier.

35
 36 Using year-end 2021 actual membership figures—meaning pending members are not included in
 37 the calculations—constituent societies would send 303 delegates to the House this year, versus 304
 38 with pending members. That number is calculated at the usual 1 per 1000, or fraction thereof,
 39 AMA members “within the jurisdiction of each constituent association” (Bylaws §2.1.1) and does
 40 not consider any other bylaws provisions such as §2.1.1.2.1, which provides an opportunity for a
 41 constituent society to at least delay the loss by filing a “written plan of intensified AMA
 42 membership development activities among its members,” thus affording the society time to
 43 recover. Should AMA membership experience a year over year decline at some point, the bylaws
 44 offer protections for the affected societies.

45
 46 The unique circumstances created by the confluence of the SARS-CoV-2 pandemic, the experiment
 47 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

REPORT OF THE HOUSE OF DELEGATES COMMITTEE
ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report June 2022

Subject: REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE
COMPENSATION OF THE OFFICERS

Presented by: Steven Tolber, MD, Chair

Referred to: Reference Committee F

1 This report by the committee at the 2022 Annual meeting presents two recommendations.

2
3 BACKGROUND

4
5 At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on
6 Trustee Compensation, currently named the Committee on Compensation of the Officers, (the
7 “Committee”). The Officers are defined in the American Medical Association’s (AMA)
8 Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the
9 HOD, Article V refers simply to “Officer,” which includes all 21 members of the Board, among
10 whom are the President, President-Elect, Immediate Past President, Secretary, Speaker and Vice
11 Speaker of the HOD, collectively referred to in this report as “Officers.” The composition,
12 appointment, tenure, vacancy process and reporting requirements for the Committee are covered
13 under the AMA Bylaws. Bylaw 2.13.4.5 provides:

14
15 The Committee shall present an annual report to the House of Delegates recommending the
16 level of total compensation for the Officers for the following year. The recommendations of the
17 report may be adopted, not adopted, or referred back to the Committee, and may be amended
18 for clarification only with the concurrence of the Committee.

19
20 At A-00, the Committee and the Board jointly adopted the American Compensation Association’s
21 definition of total compensation which was added to the Glossary of the AMA Constitution and
22 Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an
23 individual for work performance, including: (a) all forms of money or cash compensation;
24 (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

25
26 Since the inception of this Committee, its reports document the process the Committee follows to
27 ensure that current or recommended Officer compensation is based on sound, fair, cost-effective
28 compensation practices as derived from research and use of independent external consultants,
29 expert in Board compensation. Reports beginning in December 2002 documented the principles the
30 Committee followed in creating its recommendations for Officer compensation.

31
32 At A-08, the HOD approved changes that simplified compensation practices with increased
33 transparency and consistency. At A-10, Reference Committee F requested that this Committee
34 recommend that the HOD affirm a codification of the current compensation principle, which
35 occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base
36 its recommendations for Officer compensation on the principle of the value of work performed,

1 consistent with IRS guidelines and best practices recommended by the Committee's external
2 independent consultant, who is expert in Board compensation.

3
4 At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation
5 with that of all other Officers (excluding Presidents and Chair) because these positions perform
6 comparable work.

7
8 Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves
9 Group, to update his 2007 research by providing the Committee with comprehensive advice and
10 counsel on Officer compensation. The updated compensation structure was presented and approved
11 by the HOD at I-11 with an effective date of July 1, 2012.

12
13 The Committee's I-13 report recommended and the HOD approved the Committee's
14 recommendation to provide a travel allowance for each President to be used for upgrades because
15 of the significant volume of travel representing our AMA.

16
17 At I-16, based on results of a comprehensive compensation review conducted by Ms. Becky Glantz
18 Huddleston, an expert in Board Compensation with Willis Towers Watson, the HOD approved the
19 Committee's recommendation of modest increases to the Governance Honorarium and Per Diems
20 for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. At A-17 the
21 HOD approved modifying the Governance Honorarium and Per Diem definition so that Internal
22 Representation, greater than eleven days, receives a per diem.

23
24 At A-18, based on comprehensive review of Board leadership compensation, the HOD approved
25 the Committee's recommendation to increase the President, President-elect, Immediate Past-
26 President, Chair, and Chair-elect honoraria by 4% effective July 1, 2018.

27
28 At A-18 and A-19, the House approved the Committee's recommendation to provide a Health
29 Insurance stipend to President(s) who are under Medicare eligible age when the President(s) and
30 their covered dependents, not Medicare eligible, lose the President's employer provided health
31 insurance during their term as President. Should the President(s) become Medicare eligible while in
32 office, they received an adjusted Stipend to provide insurance coverage to their dependents not
33 Medicare eligible.

34
35 The Committee's I-19 report recommended and the HOD approved the Committee's
36 recommendation to increase the Governance Honorarium and Per Diem for Officers, excluding
37 Presidents and Chair, by approximately 3% each effective July 1, 2020.

38 39 FINDINGS

40
41 At I-21, this Committee recommended that an upgrade allowance in the amount of \$1250 for all
42 Officers except President, President-elect and Immediate Past President ("Leadership") be piloted
43 between November 17, 2021 through April 17, 2022. Use of the upgrade allowance for Officers
44 would comport with the current definition in the travel policy and the Board travel and expense
45 standing rules. The Committee committed to reporting on the use of the upgrade allowance during
46 the pilot and reports that during the six-month pilot, six Officers used the upgrade allowance in
47 amounts ranging from \$30 - \$616. In addition, Board Representation Office staff reported that
48 Officers were very appreciative of the availability of the upgrade allowance.

49
50 Demand for air travel has risen since the beginning of 2022. NPR (National Public Radio) reported
51 in April 2022 that based on consumer spending demand for travel this past February was 6% higher

1 than in February 2019 and was 18% higher than January 2022. In addition, as of April 18, 2022 the
2 CDC's January 29, 2021 Order requiring masks on public transportation and at transportation hubs
3 was lifted by court order. And as of May 1, the CDC website showed the number of Covid-19
4 cases slowly increasing.

5
6 Our Officers are traveling to represent the AMA while continuing to represent the AMA in
7 podcasts, on webinars, and other media to advocate on behalf of physicians and patients. Based on
8 use of the upgrade allowance during the pilot and feedback from the Officers, and to continue to
9 minimize the risks associated with crowded flights and the ease of transmission of COVID-19, the
10 Committee recommends implementing an upgrade allowance for each Officer, excluding the three
11 Presidents, in the amount of \$2500 per term beginning July 1, 2022. Use of the upgrade allowance
12 will comport with the current definition in the travel and expense standing rules and will be
13 included in the annual report of Officer Compensation presented annually to the House of
14 Delegates.

15
16 The Committee commends and thanks our Officers for their representation of the AMA.

17
18 RECOMMENDATIONS

- 19
20 1. That there be no changes to the Officers' compensation for the period beginning July 1, 2022
21 through June 30, 2023. (Directive to Take Action.)
22
23 2. That the travel policy and the Board travel and expense standing rules be amended by addition,
24 shown with underscores as follows:

25
26 Transportation

- 27 a. Air: AMA policy on reimbursement for domestic air travel for members of the Board is
28 that the AMA will reimburse for coach fare only. The Presidents (President, Immediate
29 Past President and President Elect) will each have access to an individual \$5000 term
30 allowance (July 1 to June 30) and all other Officers will each have access to \$2500 term
31 allowance (July 1 to June 30) to use for upgrades as each deems appropriate, typically
32 when traveling on an airline with non-preferred status. The unused portion of the
33 allowance is not subject to carry forward or use by any other Officer and remains the
34 property of the AMA. In rare instances it is recognized that short notice assignments may
35 require up to first class travel because of the lack of availability of coach seating, and this
36 will be authorized when necessary by the Board Chair, prior to travel. Business Class
37 airfare is authorized for foreign travel on AMA business. (Also see Rule IV –Invitations,
38 B—Foreign, for policy on foreign travel). (Directive to Take Action)
39
40 3. That the remainder of the report be filed.

Fiscal Note: Estimated cost for July 1, 2022 – June 30, 2023 is a maximum of \$52,500 if all
Presidents and Officers use the whole allowance.

APPENDIX

POSITION	GOVERNANCE HONORARIUM
President	\$290,160
Immediate Past President	\$284,960
President-Elect	\$284,960
Chair	\$280,280
Chair-Elect	\$207,480
Officers	\$67,000

Definition of Governance Honorarium Effective July 1, 2017:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils, or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted up to eleven (11) Internal Representation days.

Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation I either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating, achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is \$1400 per day.

Definition of Telephone Per Diem for External Representation effective July 1, 2017:

Officers, excluding the Board Chair and the President(s) who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for those meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem which is \$700.

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.

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

2

3 The Councils on Constitution and Bylaws and Long Range Planning and Development
4 collaborated on this report, as they did the last time these policies were up for review.

5

6 RECOMMENDATION

7

8 The Councils on Constitution and Bylaws and Long Range Planning and Development recommend
9 that the House of Delegates policies that are listed in the appendix to this report be acted upon in
10 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	<p>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;</p> <p>(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 <u>The Joint Commission</u> 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.</p>	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.	<p>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.</p>
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	<p>Retain. While the directive has been foundational for the development of many AMA policies (H-225.950, AMA Principles for</p>

		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 <u>continue</u> 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 <i>AMA House of Delegates Reference Manual: Procedures, Policies and Practices</i> 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	<p>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:</p> <ul style="list-style-type: none"> 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. <p>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</p> <p>3. Each constituent association seeking representation in the House of Delegates must agree to abide by Policy G-620.030, "Statement of Collaborative Intent."</p>	admit potential new constituent associations into our House of Delegates.
G-600.015	AMA Delegations	<p>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.</p>	<p>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.</p>
G-600.019	Probationary Period for	<p>The specialty organizations placed on one year probation are expected to work with AMA membership to develop a plan to increase their</p>	<p>Retain part of the policy. The first policy is still</p>

	Specialty Societies	<p>AMA membership and meet the responsibilities of National Medical Specialty Organizations as provided in Section 8.2 of the Bylaws.</p> <p>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.</p>	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	<p>(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):</p> <p>(a) the organization must not be in conflict with the Constitution and Bylaws of our AMA;</p> <p>(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);</p> <p>(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;</p> <p>(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;</p> <p>(e) physicians should comprise the majority of the voting membership of the organization;</p> <p>(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;</p> <p>(g) the organization must be active within the profession, and hold at least one meeting of its members per year;</p> <p>(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;</p> <p>(i) the organization must submit a resolution or other official statement to show that the request is</p>	Retain. Still relevant and necessary to specify a process to admit professional interest medical associations into our House of Delegates.

		<p>approved by the governing body of the organization; and</p> <p>(j) if international, the organization must have a US branch or chapter, and this chapter must meet the above guidelines.</p> <p>(2) The process by which PIMAs seek admission to the House of Delegates includes the following steps:</p> <p>(a) a PIMA will first apply for membership in the Specialty and Service Society (SSS);</p> <p>(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;</p> <p>(c) after three years of participation in SSS, a PIMA may apply for representation in our AMA House of Delegates;</p> <p>(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;</p> <p>(e) the Board of Trustees will recommend to the House how the application of the PIMA should be handled;</p> <p>(f) the House will determine whether or not to seat the PIMA; and</p> <p>(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.</p>	
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	<p>AMA policy on introducing business to our AMA House includes the following:</p> <p>1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The</p>	Retain. Still relevant.

		<p>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.</p> <p>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.</p> <p>3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	
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		<p>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.</p> <p>9. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is made available to the House.</p>	
G-600.061	Guidelines for Drafting a Resolution or Report	<p>Resolutions or reports with recommendations to the AMA House of Delegates shall meet the following guidelines:</p> <ol style="list-style-type: none"> 1. When proposing new AMA policy or modification of existing policy, the resolution or report should meet the following criteria: <ol style="list-style-type: none"> (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.

		<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>6. All resolutions and reports should be written to include both "MD and DO," unless specifically applicable to one or the other.</p> <p>7. Reports or resolutions should include, whenever possible or applicable, appropriate reference citations to facilitate independent review by delegates prior to policy development.</p> <p>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:</p> <ul style="list-style-type: none"> (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. <p>9. Our AMA's Board of Trustees, AMA councils,</p>	
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		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	<p>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.</p> <p>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.</p> <p>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.</p> <p>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 <i>AMA House of Delegates Reference Manual: Procedures, Policies and Practices</i>.</p> <p>5. The most recent policy shall be deemed to supersede contradictory past AMA policies.</p>	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	<p>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.</p> <p>(1) The policy consolidation process allows for: (a) rescinding outmoded and duplicative policies, and (b) combining policies that relate to the same topic.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(5) Policy Reconciliation. The AMA's policy database should not include duplicative, conflicting or inconsistent AMA policies.</p> <p>(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.</p> <p>(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</p>	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	<p>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.</p> <p>2. Our AMA will organize and implement the pilot as specified in # 1 above.</p> <p>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.</p> <p>4. State and specialty societies shall be queried on the potential number of members who would attend a new, revised interim/NAC meeting.</p>	Rescind. Policy is contrary to current Policy G-600.130, Meeting Calendar and Locations.
G-605.010	Board Planning	<p>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.</p> <p>(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.</p> <p>(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.</p> <p>(4) All Board members should have the opportunity to participate in the agenda-setting process.</p> <p>(5) The material supplied to the Board during meetings must explicitly show how these matters relate to the strategic imperatives of our AMA.</p> <p>(6) Each standing committee of the Board should develop its annual plan with progress presentations as standard items for the Board agenda/meetings.</p> <p>(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.</p>	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	<p>The AMA Board provides the following four items to the AMA House:</p> <p>(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.</p> <p>(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.</p> <p>(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</p>	Retain. Still relevant and necessary. Policy denotes annual reports submitted by the BOT.

		<p>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.</p> <p>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.</p>	
G-605.051	Situational Reporting Responsibilities of the AMA Board of Trustees	<p>The Board of Trustees provides reports to the House when the following situations occur:</p> <p>(1) the Board submits a report to the House when the Board takes actions that differ from current AMA policy;</p> <p>(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;</p> <p>(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</p> <p>(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.</p> <p>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.</p>	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	<p>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.</p> <p>(CME Rep. 5, A-05; CCB/CLRPD Rep. 3, A-12)</p> <p>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, <u>the Accreditation Council for Graduate Medical Education and its review</u></p>	Retain. Still relevant but consolidate into a single comprehensive policy H-255.988, AMA Principles on International Medical Graduates , as indicated.

		<u>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.</u>	
G-615.030	Council Activities	<p>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.</p> <p>(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)</p> <p>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, <u>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.</u></p>	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	<p>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.</p> <p>2. The COL will be represented at AMA-convened meetings focused on advocacy, such as the <u>State Advocacy Summit</u> Legislative Strategy Conference and National Advocacy Conference.</p> <p>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.</p>	Retain as editorially amended for accuracy. Still relevant.
G-615.100	Organized Medical Staff Section (OMSS)	<p>AMA policy on the Organized Medical Staff Section (OMSS) includes the following:</p> <p>(1) Our AMA encourages all U.S. hospitals to support representation of their medical staffs in our AMA Organized Medical Staff Section meetings;</p> <p>and (2) Our AMA will continue to (a) communicate to the chiefs of staff of hospitals and executive directors of organized medical groups the</p>	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	<p>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</p>	<p>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.</p>
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		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

		<p>presented to the House of Delegates.</p> <p>(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.</p> <p>(2) OVERVIEW OF PRINCIPLES. The AMA's principles to guide corporate relationships have been organized into the following categories:</p> <p>General Principles that apply to most situations;</p> <p>Special Guidelines that deal with specific issues and concerns;</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(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</p>	functioning of the AMA
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		<p>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.</p> <p>(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 objectivity 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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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</p>	
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		<p>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.</p> <p>(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.)</p> <p>(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.</p> <p>(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,</p>	
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		<p>its policies and/or its products.</p> <p>(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.</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(c) The Executive Vice President is responsible for</p>	
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		<p>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.</p> <p>(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.</p> <p>(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.</p> <p>(6) ORGANIZATIONAL CULTURE AND ITS INFLUENCE ON EXTERNALLY FUNDED PROGRAMS.</p> <p>(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.</p> <p>(b) As a professional organization, our AMA operates with a higher level of purpose representing</p>	
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		<p>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.</p> <p>(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.</p>	
G-630.090	AMA Publications	<p>AMA policy on its publications includes the following:</p> <p>(1) JAMA and other AMA scientific journals should display a disclaimer in prominent print that the editorial views are not necessarily AMA policy.</p> <p>(2) Our AMA, in all of its publications and correspondence, will use the correct title for the medical specialist.</p> <p>(3) Our AMA recommends that medical journal articles using acronyms should have a small glossary of acronyms and phrases displayed prominently in the article.</p> <p>(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.</p>	Retain. Still relevant.
G-630.100	Conservation, Recycling and Other 'Green' Initiatives	<p>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.</p>	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.

		<p>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</p> <p>(6) will expand its database of information on osteopathic students and doctors.</p>	
G-635.120	Dues Strategy	<p>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.</p> <p>(2) Relying upon survey and other relevant data, our AMA Board of Trustees shall determine the dues and benefits of the International membership category.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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</p>	Rescind. Policy has been implemented.

		<p>membership can be held to a realistic figure.</p> <p>(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.</p> <p>(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.</p> <p>(10) Our AMA will make a major organizational effort to persuade physicians' employers to allocate funds for professional development and Federation dues.</p> <p>(11) The House of Delegates approves the Partnership for Growth's Direct Program marketing entry date of February 1.</p>	
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

1 Whereas, The questions regarding life and death have been debated by scholars, philosophers,
2 religious leaders and doctors for centuries and technology has blurred the distinction between a
3 quality human life and biological life on a cellular or organ basis; and
4

5 Whereas, Economic, social and religious views influence modern definitions of human and
6 biological life, making technology in modern medicine a double-edged sword, favoring the
7 betterment of patients and their quality of life and care; and
8

9 Whereas, Physicians have been sworn to do no harm, yet this is increasingly challenging with
10 today's competing forces of technology, shifting social morae's and the economics and
11 legislation of health care; and
12

13 Whereas, Confronted/ burdened with the more complicated questions of when life begins and
14 ends, physicians have not always been able to transition patients effectively from life to death,
15 which has contributed to decreased use of tools such as palliative care and hospice care; and
16

17 Whereas, End-of-life care as defined by the World Health Organization (WHO) "is the term used
18 to describe the support and medical care given during the time surrounding death"; and
19

20 Whereas, Palliative Care is the treatment of patients with serious illnesses and disease with the
21 goal to help the patient feel better, prevent or alleviate symptoms and side effects of disease
22 and treatment, treating the whole patient including the emotional, social, practical, and spiritual
23 costs of that illnesses, striving to improve a patient's quality of life as they deal with serious
24 illness; and
25

26 Whereas, Hospice is the treatment of patients at the end of life or with a terminal illness,
27 generally for patients who have less than six months to live and which uses many elements of
28 palliative care to keep patients comfortable during their transition from life to death; and
29

30 Whereas, Physicians need to educate themselves on what the treatment goals offer and the
31 reasonableness of the outcome, while all physicians should understand what palliative and
32 hospice care offer a patient in terms of treatment, palliative care is an appropriate bridge to
33 care; and
34

35 Whereas, There needs to be more certificate programs for physicians on palliative care until such
36 time as there are enough fellowship trained end of life physicians, education is critical with respect
37 to hospice care which does not mean "no care" but should redefine the scope of care; and

1 Whereas, Currently, the delivery of end of life care is fragmented with services provided in the
2 hospital, skilled nursing facility or community with each setting having different resources,
3 definitions and protocols and no seamless way to transfer patients from one setting to the next
4 and back again; and

5
6 Whereas, The current “one size fits all” approach does little to address the spectrum of end of
7 life issues but reinforces the need for a centralized depository of end of life orders that is easily
8 accessible; therefore be it

9
10 RESOLVED, That our American Medical Association develop educational resources for
11 physicians, allied health professionals and patients on end of life care (Directive to Take Action);
12 and be it further

13
14 RESOLVED, That our AMA work with all stakeholders to develop proper quality metrics to
15 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

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

1 Whereas, September 11, 2001 took over 3,000 lives in an act of terrorism against the United
2 States of America; and

3
4 Whereas, September 11, 2021 marked the twentieth anniversary of that horrific day; and

5
6 Whereas, Thousands of responders, uniformed and civilian, employed and volunteers, served at
7 Ground Zero, the Pentagon and Shanksville, PA, risking their lives, being exposed to debris,
8 powdered cement, fumes, vapors, dust, and a variety of other irritants, including exposure to
9 human remains, as well as many severe psychological stressors, and the devastation to the
10 World Trade Center site itself; and

11
12 Whereas, There are many Americans who now live with September 11 related medical and
13 mental health conditions as well as those whose lives were prematurely shortened because of
14 the impact of these toxic exposures; and

15
16 Whereas, The effects of the 9/11 attack have forever altered the world in every aspect of life
17 from mental, emotional, medical, business, security, education, etc.; and

18
19 Whereas, Every American and every individual has felt the impact from lost loved ones who
20 were taken away too early, or from the increased security and vigilance needed to protect this
21 country; and

22
23 Whereas, Every life lost on that day represents the freedoms for which we were attacked; and

24
25 Whereas, *Patriot Day, 9/11*, is already recognized as a day of remembrance; and

26
27 Whereas, The terror attack on US soil on September 11, 2001 should never be minimized or
28 forgotten; and

29
30 Whereas, The United States Congress holds the authority to create a Federal Holiday according
31 to Title V of the United States Code (5 U.S.C. 6103); therefore be it

32
33 RESOLVED, That our American Medical Association support and recognize September 11th as
34 an annual day of observance to remember and recognize all who died and who continue to
35 suffer health consequences from the events of 9/11, to honor first- and all responders from
36 around the country, and to recognize and forever remind us of the unity our country experienced
37 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

1 Whereas, The General Assembly of the United Nations advocates for proclaiming International
2 days of recognition to highlight specific values of worldwide human interest; and
3

4 Whereas, The United Nations General Assembly documents describe the purpose of
5 proclaiming “International Days” as follows: “International days are occasions to educate the
6 general public on issues of concern, to mobilize political will and resources to address global
7 problems, and to celebrate and reinforce achievements of humanity”; and
8

9 Whereas, The year marks the 80th year from the first recorded use of radioiodine therapy to
10 treat human disease; and
11

12 Whereas, Saul Hertz, MD (1905 - 1950) discovered the medical uses of radionuclides, and his
13 breakthrough work with radioactive iodine (RAI) created a dynamic paradigm change integrating
14 the sciences of physics, biology, physiology and medicine; and
15

16 Whereas, Radioactive iodine (RAI) is the first and remains the Gold Standard of targeted cancer
17 therapies; and
18

19 Whereas, In early 1941, Dr. Hertz administered the first therapeutic treatment of (Cyclotron-
20 produced) radioactive iodine (RAI) at the Massachusetts General Hospital, which led to the first
21 series of twenty-nine patients with hyperthyroidism being treated successfully with RAI; and
22

23 Whereas, Dr. Hertz expanded the successful use of RAI of treating hyperthyroidism and Graves’
24 disease to the treatment of thyroid cancer in 1946; and
25

26 Whereas, This work generating and utilizing radioactive material for medical therapy leaves an
27 enduring legacy, impacting countless generations of patients, numerous institutions worldwide
28 and setting the cornerstone for the field of Nuclear Medicine, and has for all future generations,
29 augmented and forever altered the approach to medical therapies; and
30

31 Whereas, This novel work marks the advent of what we now recognize as modern medicine,
32 utilizing molecular medicine and the ever evolving promise of targeted molecular therapies for
33 the treatment of human disease; and
34

35 Whereas, To appropriately recognize and honor this groundbreaking scientific and medical
36 breakthrough on its 80th year anniversary, and to honor Dr. Saul Hertz and to remember and
37 celebrate this extraordinary accomplishment; therefore be it

- 1 RESOLVED, That our American Medical Association support the efforts of the American
- 2 College of Nuclear Medicine to create and introduce a United Nations General Assembly
- 3 (UNGA) Resolution for the creation of a new International Day of recognition with the suggested
- 4 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
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6357704/>
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<http://saulhertzmd.com/home>

TABLE I AN ANALYSIS OF CASES "NOT CURED" BY $RaI + KI$ (10 MARCH '46)								% OF RaI (URINE) EXCRETED - 72 HRS.			
SERIES NO.	CASE-HOSP NO.	BMR PRIOR TO I^{131}	DOSAGE OF I^{131} and DATE OF ADMINISTRATION	BMR PRIOR TO SUB-TOTAL THYROIDECTOMY	DUSTON THYROID WEIGHT	HISTOLOGY	TOTAL THYROID IRRADIATION (m) 12 HR	9 DAY	ESTIMATED THYROID WT. BEFORE I^{131}	FOLLOWING THE ADMINISTRATION OF I^{131}	
1	ELIZABETH D.	+30	21mC 3-31-41 } 3.6 1.5mC 4-16-41 } mC	(-3)(-7)	(-29)	34	INVOLUTION	470 220	660 240	35	20 28
5		+35	57mC 7-11-41	ALARMED EXAMINATION	(-20)	31	HYPERPLASIA NO INVOL.	1000	1150	40	27
10		+55	07mC 2-2-42	(+3)	(-26)	26 30	HYPERPLASIA MOD. INVOL.	120	80	60	38
14		+50	15mC 7-15-42	(-15)	(-24)	55	HYPERPLASIA + INVOLUTION	650	—	60	71
16		+25	10mC 8-11-42	(-8)	(-24)	28	INVOLUTION	1800	—	45	6
19		+65	18mC 8-28-42 } 28 8mC 3-8-43 } mC 5mC 3-9-43 }	(+8) TO (+5)	(-36) TO (-10)	35	HYPERPLASIA + INVOLUTION	2000 1500	—	60	9 15 7
2		+35	14mC 5-10-41 } 5.6 0.9mC 41 } mC 2.0mC 42 } 0.8mC 42 }	NOT OPERATED PERSISTENT THYROTOXICOSIS ANOTHER 20mC PROPOSED			160 110 120 100	140 100 120 100	40	54 48 78 —	
4		+30	3.6mC 7-18-41 } 5.8 2.2mC 7-31-41 } mC	EYES BETTER. NO GOITER. BMR (+2) OFF MED. - 4 YRS			270 170	300 180	60	55 56	
3		+50	34mC 6-6-41 20mC 1-9-46	REMISSION FOR 1 YR. - THEN (RECENTLY FOR TRUE RECURRENCE)			430 4300	410 —	45 30 (AUGURENS)	45 35	

* OPHTHALMOPATHIC TYPE

* OPHTHALMOPATHIC TYPE

SERIES NO.	CASE-HOSP NO.	DOSE OF I^{131} and DATE OF ADMINISTRATION	BMR BEFORE I^{131}	BMR LEVEL OFF IODIDES	TIME OFF IODIDES	THYROID SIZE '46	ESTIMATED THYROID WT. (gm)	% OF RaI EXCRETED 72 HOURS	ESTIMATED THYROID IRRADIATION (m) 12 HOUR	8 DAYS *
6		2.3mC 7-24-41 } 4.0 1.7mC 7-30-41 } mC	+45	DEC. '42 (-9) MAY. '43 (-16) JAN. '46 (-7)	4 YRS. +	N	45	35 22	320 280	390 300
7		ET 9.) 1.4mC 9-19-41 } 2.9 1.5mC 9-21-41 } mC	+65	1-8-46 (-6)	4 YRS.	N	45	9 20(?)	260 260(?)	280 220(?)
8		ET 9.) 1.6mC 9-24-41	+30	7-17-45 (-3) 5-27-46 (+4)	7 MOS	FIRM 2 X N	40	15	300	250
9		4.9mC 11-26-41	+30	5-8-45 (-10)	4 YRS.	N	60	17	650	420
11		5.8mC 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		7.5mC 5-15-42	+55	45 (+11) 2-3-46 (-13)	3 YRS.	HARD 1.5 X N	60-75	26	950	500
13		12mC 6-9-42	+30	3-45 (+6) 2-3-46 (-10)	3 YRS.	N	40	71	750	
15		6mC 8-11-42 } 10 4mC 8-11-42 } mC	+35	4-45 (-6) 2-3-46 (+2)	10 MOS.	N	40	10	2000	
17		13mC 8-15-42	+50	6-10-44 (-15) 1-6-46 (-9)	3 YRS. +	N	60	14	1300	
18		10.5mC 8-15-42	+35	8-22-44 (-19) 2-16-46 (-4)	3 YRS. +	N	40	15	2000	
20		10mC 11-14-42	+50	4-3-45 (-1) 2-16-46 (-5)	2 YRS. +	N	45	20	1600	
21		14mC 11-20-42	+45	1-8-46 (-13)	3 YRS. +	N	50	15(?)	2000	
22		13mC 3-9-43	+20	6-30-43 (-8)	2 YRS. +	? N (LMB)	55	33	2200	
23		8mC 3-15-43 } 18 10mC 3-16-43 } mC	+55	6-9-43 (-11) 2-16-46 (-3)	2 YRS. +	FIRM 1.5 X N	75	76 67	500	
24		10.5mC 3-26-43 } 15 4.5mC 3-27-43 } mC	+40	12-45 (-5)	2 YRS. +	N (Dr. J.C.) (ZILHARDT)	50	57 31	1000	
25		16mC 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		12mC 4-6-43	+39	45 (-8) 1-16-46 (-2)	2 YRS. +	N	45	85	350	
27		13mC 4-12-43	+40	7-17-45 (-16) 2-15-46 (-10)	2 YRS. +	N	50	33	1600	
28		10.5mC 4-13-43 } 2 11.0mC 4-13-43 } mC	+55	12-45 (-6) 2-3-46 (+6)	2 YRS. +	N	75	---?	2000	
29		8mC 3-29-43 } 12 4mC 3-30-43 } 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

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

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 levels³ higher than
9 ever before since the evolution of homo sapiens⁴; 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 alone⁵, 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 steadily⁶, 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 level⁷; 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 workers⁸, communities disproportionately burdened by poor environmental quality⁹, and some
27 communities in the rural Southeastern United States¹⁰; 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 processes¹¹; 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 2050¹²; thus we have a vanishing
37 window of opportunity for meaningful action; and

1 Whereas, Many climate change mitigation interventions have immediate local air quality
2 benefits, among others, and thus immediate health co-benefits¹³; and
3

4 Whereas, Cutting GHG emissions “may appear to be difficult and costly, but its near-term
5 benefits outweigh its costs in many areas¹⁴; and
6

7 Whereas, It is estimated that worldwide 10.2 million premature deaths annually are attributable
8 to the fossil-fuel component of PM2.5, constituting nearly 18% of premature deaths¹⁵; and
9

10 Whereas, Worldwide, tobacco use causes more than seven million deaths per year¹⁶; and
11

12 Whereas, Our AMA has extensive policy to organize physician leadership vis a vis tobacco’s
13 public health harms¹⁷; and
14

15 Whereas, The Tobacco Industry and Fossil Fuel Industry business models are similar in that
16 their products are incongruous with the interests of public health and their profit interests
17 motivate well-funded misinformation campaigns¹⁸; and
18

19 Whereas, “The strategy, tactics, infrastructure, and rhetorical arguments and techniques used
20 by fossil fuel interests to challenge the scientific evidence of climate change—including cherry
21 picking, fake experts, and conspiracy theories—come straight out of the Tobacco Industry’s
22 playbook for delaying tobacco control”¹⁹; and
23

24 Whereas, Physicians are uniquely trusted messengers, with a unique responsibility to advocate
25 politically for policies to safeguard health in the face of any public health crisis, whether the
26 COVID-19 pandemic or the climate crisis, in order to build social will for science-based policy
27 action; and
28

29 Whereas, Our AMA has adopted multiple policies addressing climate change (H-135.919, H-
30 135.938, H-135.977, H-135.923, D-135.968, D-135.969, H-135.973), but these policies fall short
31 of coordinating strategic physician advocacy leadership on the scale necessary for such a
32 health crisis; and
33

34 Whereas, In the face of the existential threat that the climate crisis poses, the aforementioned
35 policies have not been leveraged to fulfill our AMA’s Declaration of Professional Responsibility
36 (H-140.900) which states, “We, the members of the world community of physicians, solemnly
37 commit ourselves to ‘Medicine’s Social Contract with Humanity’ in order to continue to earn
38 society’s trust in the healing profession, by, among other oaths, promising that we will ‘Educate
39 the public and polity about present and future threats to the health of humanity’”; and
40

41 Whereas, Our AMA has no identified longitudinal body or Center for coordinating and
42 centralizing the Association’s efforts to address climate change which the WHO calls “...the
43 greatest threat to global health in the 21st century”²⁰; and
44

45 Whereas, Our AMA Corporate Policies on Tobacco H-500.975: resolved that (1) Our AMA: (a)
46 continues to urge the federal government to reduce and control the use of tobacco and tobacco
47 products; (b) supports developing an appropriate body for coordinating and centralizing the
48 Association’s efforts toward a tobacco-free society; and (c) will defend vigorously all attacks by
49 the tobacco industry on the scientific integrity of AMA publications; therefore be it

1 RESOLVED, That our American Medical Association reaffirm Policy H-135.949, "Support of
2 Clean Air and Reduction in Power Plant Emissions," (Reaffirm HOD Policy); and be it further

3
4 RESOLVED, That our AMA establish a climate crisis campaign that will distribute evidence-
5 based information on the relationship between climate change and human health, determine
6 high-yield advocacy and leadership opportunities for physicians, and centralize our
7 AMA's efforts towards environmental justice and an equitable transition to a net-zero
8 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

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, parenthetical 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; Reaffirmation 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

1 Whereas, Our AMA recognizes the urgent, ongoing health threats posed to our patients by
2 global climate change,^{1,5} which on its current trajectory is likely to far exceed the health impacts
3 of COVID19 and HIV combined; and
4

5 Whereas, Our AMA has declared “the importance of physician involvement in policymaking at
6 the state, national, and global level and supports efforts to search for novel, comprehensive,
7 and economically sensitive approaches to mitigating climate change to protect the health of the
8 public; and recognizes that whatever the etiology of global climate change, policymakers should
9 work to reduce human contributions to such changes”¹; and
10

11 Whereas, In 2018, our AMA adopted policy that “AMA, AMA Foundation, and any affiliated
12 corporations will work in a timely, incremental, and fiscally responsible manner, to the extent
13 allowed by their legal and fiduciary duties, to end all financial investments or relationships
14 (divestment) with companies that generate the majority of their income from the exploration for,
15 production of, transportation of, or sale of fossil fuels”²; and
16

17 Whereas, Many health and life insurance companies followed the example of the AMA by
18 divesting from tobacco companies because the tobacco industry’s products and marketing
19 strategies so clearly threaten human health; and
20

21 Whereas, Moody’s Investors Service warned investors in 2017 that the oil and gas industry
22 faces significant credit risks due to the world’s ongoing transition away from fossil fuel³; and
23

24 Whereas, The top 10 U.S. health insurers, ranked by U.S. market share and for whom there are
25 publicly disclosed fossil fuel investment data, have invested nearly \$24 billion dollars in fossil
26 fuels companies;⁴ and
27

28 Whereas, Collectively, the largest nineteen health or life insurance companies have declared
29 investments of more than over \$183 billion in the fossil fuel industry⁴; therefore be it
30

31 RESOLVED, That our American Medical Association declare that climate change is an urgent
32 public health emergency, and calls upon all governments, organizations, and individuals to work
33 to avert catastrophe (New HOD Policy); and be it further
34

35 RESOLVED, That our AMA urge all health and life insurance companies, including those that
36 provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and
37 fiscally responsible manner to end all financial investments or relationships (divestment) with
38 companies that generate the majority of their income from the exploration for, production of,
39 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

1 Whereas, An essential function of organized medicine is to represent the voice of their members
2 and patients; and
3

4 Whereas, Significant resources are spent in terms of time and money across the local, state and
5 national levels of organized medicine in the formulation of a wide scope of policy resolutions;
6 and
7

8 Whereas, These resolutions undergo extensive debate with resulting dismissal, passage or
9 referral at the respective state and/or national levels; and
10

11 Whereas, Approved resolutions and reports fall across different areas of priority and action; and
12

13 Whereas, Given the volume of resolutions and reports, the vast majority of policy statements
14 and/or recommendations fail to be effectively disseminated back to the local or state
15 membership, in addition to our patients; and
16

17 Whereas, Given the volume of resolutions and reports there currently is no system in place to
18 provide surveillance management of the eventual outcome for the respective resolution and/or
19 report; and
20

21 Whereas, The lack of timely, transparent and effective communication of the work performed by
22 organized medicine, including at state and national House of Delegates, likely contributes to the
23 apathy, disengagement and/or lack of membership (including renewal) by physicians at the local
24 and state levels; and
25

26 Whereas, The practice of medicine is subject to performance metrics, including process and
27 outcome in addition to surveys of satisfaction and service; therefore be it
28

29 RESOLVED, That our American Medical Association develop a prioritization matrix across both
30 global and reference committee specific areas of interest (Directive to Take Action); and be it
31 further
32

33 RESOLVED, That our AMA develop a web-based surveillance management system, with
34 pre-defined primary and/or secondary metrics, for resolutions and reports passed by their
35 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

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 65²,
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 Report⁴ 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 ADA⁵ 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

1. Okoro, C. A., Hollis, N. D., Cyrus, A. C., & Griffin-Blake, S. (2018). Prevalence of disabilities and health care access by disability status and type among adults—United States, 2016. *Morbidity and Mortality Weekly Report*, 67(32), 882-887.
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 \(ama-assn.org\)](https://www.ama-assn.org/about/long-range-planning-and-development/council-on-long-range-planning-and-development)
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 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.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 611
(A-22)

Introduced by: Minority Affairs Section, National Medical Association

Subject: Continuing Equity Education

Referred to: Reference Committee F

Whereas, The AMA has recently taken significant steps to achieve optimal health for all in the areas of scholarship, research, philanthropy, advocacy, healthcare delivery, and practice through the adoption and implementation of policies, processes, and programs that center equity, such as the founding of the AMA Center for Health Equity and adoption of several racial justice and equity-oriented policies by the House of Delegates¹; and

Whereas, In May 2021, the Center for Health Equity released its three-year organizational strategic action plan to embed racial justice and advance health equity within the AMA and across medicine, and has since taken the initial steps to operationalize this mission, including the collaborative release of *Advancing Health Equity: A Guide to Language, Narrative and Concepts* to provide a shared framework for the discussion of health equity issues²⁻⁴; and

Whereas, In response to member requests to expand and deepen their understanding of health equity and racial justice, the AMA Board of Trustees and Speakers arranged for the convening of an Open Forum on Health Equity during the November 2021 (N21) Special Meeting of the House of Delegates (HOD) to facilitate additional opportunities for education and discussion among membership^{5,6}; and

Whereas, The N21 Health Equity Forum granted HOD members a safe environment to participate in curated education sessions and programming with health equity experts and scholars, providing information exchange and valuable perspective into the importance of learning life-long skills and furthering knowledge to prioritize equity; therefore be it

RESOLVED, That our American Medical Association establish an Open Forum on Health Equity, to be held annually at a House of Delegates Meeting, for members to directly engage in educational discourse and strengthen organizational capacity to advance and operationalize equity. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000; however, honoraria and/or speakers' fees may result in significantly larger and variable annual cost.

Received: 05/09/22

References:

1. Keelys M, Baca J, Maybank A. Race, Racism, and the Policy of 21st Century Medicine. *Yale J Biol Med*. 2021;94(1):153-157
2. American Medical Association. AMA releases plan dedicated to embedding racial justice and advancing health equity. Published May 11, 2021. Accessed November 1, 2021. <https://www.ama-assn.org/press-center/press-releases/ama-releases-plan-dedicated-embedding-racial-justice-and-advancing>
3. American Medical Association. Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity. Published May 11, 2021. Accessed November 1, 2021. <https://www.ama-assn.org/system/files/2021-05/ama-equity-strategic-plan.pdf>
4. Association of American Medical Colleges. American Medical Association. Advancing Health Equity: A Guide to Language, Narrative, and Concepts. Published October 28, 2021. Accessed November 1, 2021. <https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf>
5. Kridel, R. A Communication from the Board Chair. *American Medical Association*. June 1, 2021.
6. Scott, B, Egbert, L. Speakers' Letter Special Meeting of the AMA House of Delegates November 12-16, 2021. *American Medical Association*. October 12, 2021.

RELEVANT AMA POLICY

Plan for Continued Progress Toward Health Equity D-180.981

1. Our AMA will develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities.
2. The Board will provide an annual report to the House of Delegates regarding AMAs health equity activities and achievements.

Citation: BOT Rep. 33, A-18

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

Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions H-65.951

Our AMA adopted the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:

GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.
- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Create anti-discrimination policies that:
 - Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
 - Define expected and prohibited behavior.
 - Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
 - Ensure privacy and confidentiality to the reporter.
 - Provide a confidential method for documenting and reporting incidents.
 - Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.
- These policies should include:
 - Taking every complaint seriously.
 - Acting upon every complaint immediately.
 - Developing appropriate resources to resolve complaints.
 - Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
 - Communicating decisions and actions taken by the organization following a complaint to all affected parties.
 - Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:

- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
 - Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.
 - Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or

encounters with behavior that may constitute discrimination, including racism, bias or microaggressions.

- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.
- Providing designated support person to confidentially accompany the person reporting an event through the process.

Citation: Res. 003, A-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

Underrepresented Student Access to US Medical Schools H-350.960

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; and (5) recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations.

Citation: Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, 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

Promising Practices Among Pathway Programs to Increase Diversity in Medicine D-350.980

Our AMA will establish a task force to guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education.

Citation: CME Rep. 5, A-21

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

Training Physicians and Physicians-in-Training in the Art of Public Speaking H-445.984

1. Physicians who want to learn more about public speaking can leverage existing resources both within and outside the AMA. AMA can make public speaking tips available through online tools and resources

that would be publicized on our website. Physicians and physicians-in-training who want to publicly communicate about the AMA's ongoing work are invited to learn more through the AMA Ambassador program.

Meanwhile, STEPS Forward provides helpful tips to physicians and physicians-in-training wanting to improve communication within their practice and AMPAC is available for physicians and physicians-in-training who want to advocate and communicate about the needs of patients, physicians, and physicians-in-training in the pursuit of public office. There are also resources provided to physicians and physicians-in-training at various Federation organizations and through the American Association of Physician Leadership (AAPL) to support those who are interested in training of this nature.

Because public speaking is a skill that is best learned through practice and coaching in a small group or one-on-one setting, we also encourage individuals to pursue training through their state or specialty medical society or through a local chapter of Toastmasters International.

The Board of Trustees recommends that the AMA's Enterprise Communications and Marketing department work to develop online tools and resources that would be published on the AMA website to help physicians and physicians-in-training learn more about public speaking.

2. Our AMA will offer live education sessions at least annually for AMA members to develop their public speaking skills.

Citation: BOT Rep. 10, I-18

Activities of the Council on Legislation G-615.071

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 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.

Citation: (BOT Rep. 12, A-07; Reaffirmed: BOT Rep. 4, I-10; Modified: CCB/CLRPD Rep. 3, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 612
(A-22)

Introduced by: Minority Affairs Section, National Medical Association

Subject: Identifying Strategies for Accurate Disclosure and Reporting of Racial and Ethnic Data Across the Medical Education Continuum and Physician Workforce

Referred to: Reference Committee F

1 Whereas, Our AMA established policy permits coordination and transfer of voluntarily provided
2 racial data from the Association of American Medical Colleges (AAMC) to the AMA Physician
3 Masterfile, which includes current and history data for more than 1.4 million physicians, fellows,
4 residents, and medical students in the United States; and

5
6 Whereas, AAMC applications such as AMCAS, MCAT, and ERAS utilize a two-tier analysis for
7 race data, with tier one presenting the data by race only when one race is selected, and all
8 others as “two or more races” (ensuring no student is counted more than once), with tier two
9 presenting data by race, including any student who indicated a racial category whether alone or
10 “in combination” with other races (ensuring medical schools, residency, and fellowship programs
11 have an accurate count of students who identify as each race);¹ and

12
13 Whereas, The U.S. Department of Education (DOE) race reporting requirements only has the
14 first tier of race reporting, which therefore excludes reporting any race data for respondents who
15 indicate more than one race;² and

16
17 Whereas, AAMC data illustrates an example of how disparate DOE race data requirements are,
18 with the 1,010 current US medical students who identify as American Indian/Alaska Native
19 (AI/AN), 17% report AI/AN as their only race, meaning that under DOE race requirements, 83%
20 of AI/AN students would have no race data reported;³ and

21
22 Whereas, The inconsistency of the data between pre-medical students and medical students
23 due to these divergent policies can contribute to difficulties identifying problem areas where
24 additional support could improve underrepresented students’ chances of becoming a medical
25 student, resident/fellow, and finally a practicing physician; therefore be it

26
27 RESOLVED, That our American Medical Association adopt racial and ethnic demographic data
28 collection practices that allow self-identification of designation of one or more racial categories
29 (Directive to Take Action); and be it further

30
31 RESOLVED, That our AMA report demographic physician workforce data in mutually exclusive
32 categories of race and ethnicity whereby Latino, Hispanic, and Other Spanish ethnicity and
33 Middle Eastern North African ethnicity are categories, irrespective of race (Directive to Take
34 Action); and be it further

1 RESOLVED, That our AMA adopt racial and ethnic physician workforce demographic data
 2 reporting practices that permit disaggregation of individuals who have chosen multiple
 3 categories of race so as to distinguish each category of individuals' demographics as alone or in
 4 combination with any other racial and ethnic category (Directive to Take Action); and be it
 5 further
 6

7 RESOLVED, That our AMA collaborate with AAMC, ACGME, AACOM, AOA, NBME, NBOME,
 8 NRMP, FSBM, CMSS, ABMS, HRSA, OMB, NIH, ECFMG, and all other appropriate
 9 stakeholders, including minority physician organizations, and relevant federal agencies to
 10 develop standardized processes and identify strategies to improve the accurate collection,
 11 disclosure and reporting of racial and ethnic data across the medical education continuum and
 12 physician workforce. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is \$150K-\$175K.

Received: 05/09/22

References:

1. Association of American Medical Colleges. FACTS Glossary. 2021. Accessed May 2, 2022. <https://www.aamc.org/data-reports/students-residents/interactive-data/facts-glossary>
2. Office of Management and Budget. (1997b) Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, Federal Register: 62: No.210, October 30.
3. Association of American Medical Colleges. 2021 FACTS: Enrollment, Graduates, and MD-PhD Data. Accessed May 2, 2022. <https://www.aamc.org/data-reports/students-residents/interactive-data/2021-facts-enrollment-graduates-and-md-phd-data>

RELEVANT AMA POLICY

Race and Ethnicity as Variables in Medical Research H-460.924

Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately; (2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations; (3) physicians recognize that race and ethnicity are conceptually distinct; (4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants; (5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected; (6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and (7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.

Citation: CSA Rep. 11, A-98; Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 01, A-21

Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent D-350.979

Our 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.

Citation: Res.19, I-21

AMA Race/Ethnicity Data D-630.972

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.

Citation: (BOT Rep. 24, I-06; Modified: CCB/CLRPD Rep. 3, A-12)

Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities H-315.963

Our 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.

Citation: Res. 03, I-19

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

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

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its stance on diversity in medical education;

(2) request that the Liaison Committee on Medical Education regularly share statistics related to

compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; and (5) work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates.

Citation: Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13;
Appended: CME Rep. 5, A-21

Patient and Physician Rights Regarding Immigration Status H-315.966

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

Citation: Res. 018, A-17

Racial and Ethnic Identity Demographic Collection by the AMA D-350.982

Our 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.

Citation: Res. 614, A-19

Discriminatory Policies that Create Inequities in Health Care H-65.963

Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.

Citation: Res. 001, A-18

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

Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;

4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and

5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

Citation: Res. 307, A-09; Appended: Res. 955, I-17

Underrepresented Student Access to US Medical Schools H-350.960

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; and (5) recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations.

Citation: Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21

AMA Initiatives Regarding Minorities H-350.971

The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components:

- (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine;
- (2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities;
- (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;
- (4) Response to inquiries and concerns of minority physicians and medical students; and
- (5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.

Citation: CLRPD Rep. 3, I-98; CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20

National Resident Matching Program Reform D-310.977

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;
- (2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
- (3) will request that the NRMP explore the possibility of including the Osteopathic Match in the

NRMP Match;

- (4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises;
- (5) will work with the Accreditation Council for Graduate Medical Education (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 match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
- (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant;
- (9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
- (10) will work with the 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.

Citation: CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 613
(A-22)

Introduced by: California

Subject: Timing of Board Report on Resolution 605 from N-21 Regarding a Permanent Resolution Committee

Referred to: Reference Committee F

1 Whereas, Resolution 605 from N-21 regarding establishment of a Resolution Committee was
2 referred to the Board of Trustees for study without specified timing for report back to the House
3 of Delegates; and
4

5 Whereas, The subject matter of Resolution 605 from N-21 is of significant interest and
6 importance to the House of Delegates; therefore be it
7

8 RESOLVED, That the Report of the Board of Trustees regarding Resolution 605 from N-21 be
9 presented to the American Medical Association House of Delegates with recommendation(s) for
10 the House of Delegates to be voted upon at the 2022 Interim Meeting. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 05/09/22

Resolution 605 (N-21): Formalization of the Resolution Committee as a Standing Committee of the American Medical Association House of Delegates was **referred** by the N-21 House of Delegates.

RELEVANT AMA POLICY

Resolution Committee. B-2.13.3

The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.

2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.

2.13.3.2 Size. The committee shall consist of a maximum of 31 members.

2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.

2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.

2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.

2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.

2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 614
(A-22)

Introduced by: Albert L. Hsu, MD, Delegate

Subject: Allowing Virtual Interviews on Non-Holiday Weekends for Candidates for
AMA Office

Referred to: Reference Committee F

1 Whereas, In Year 1 of the COVID-19 pandemic (in accordance with AMA election guidelines),
2 the Endocrine Section Council of the American Medical Association conducted virtual interviews
3 for 7 of 8 candidates for AMA Board of Trustees and all 5 candidates for AMA Council on
4 Medical Service on Sat., 30 May, 2020 (and the one BOT candidate with a conflict was able to
5 meet virtually on an alternate and mutually-convenient date); and
6

7 Whereas, In Year 2 of the COVID-19 pandemic (and in accordance with AMA election
8 guidelines), the Endocrine Section Council of the AMA conducted virtual interviews for all 12
9 candidates for AMA President-elect, AMA Board of Trustees, the AMA Council on Science and
10 Public Health, the AMA Council on Constitution and Bylaws, and the AMA Council on Medical
11 Service on Sat., 22 May, 2021; and
12

13 Whereas, In Year 3 of the COVID-19 pandemic, and in response to action by the AMA House of
14 Delegates, all virtual interviews for Candidates for AMA Elections (President-elect, Board of
15 Trustees, and all Councils) were required to be held between Thur., 26 May-Sun., 29 May,
16 which was over Memorial Day weekend; and
17

18 Whereas, In 2022, seven groups have offered virtual interviews to candidates for AMA Office;
19 and
20

21 Whereas, Virtual interviews allow caucuses to meet candidates for AMA Office before the in-
22 person meeting, without the distractions of AMA business and policy-making, networking, and
23 catching up with old friends; and
24

25 Whereas, Virtual interviews allow candidates for AMA office to hone their speeches and
26 presentations before the in-person meeting; and
27

28 Whereas, Current AMA-HOD policy states that: "Interviews may be conducted only during a
29 window beginning on the Thursday evening two weeks prior to the scheduled Opening Session
30 of the House of Delegates meeting at which elections will take place and must be concluded by
31 that Sunday (four days later);" and
32

33 Whereas, Memorial Day weekend is a decidedly inconvenient time to conduct virtual interviews,
34 making "work-life balance" even more difficult (for both candidates and caucuses alike);
35 therefore be it

1 RESOLVED, That our AMA amend policy G-610.020, "Rules for AMA Elections," by addition
2 and deletion to read as follows:

3
4 Interviews may be conducted only during a window designated by the Speaker
5 beginning on the Thursday evening of a non-holiday weekend at least two weeks
6 but not more than 4 weeks prior to the scheduled Opening Session of the House of
7 Delegates meeting at which elections will take place and must be concluded by
8 that following Sunday ~~(four days later)~~. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 05/11/22

REFERENCES:

1. 2022 AMA Elections Manual

RELEVANT AMA POLICY

Rules for AMA Elections G-610.020

- (1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker and the Election Committee, is responsible for declaring a violation of the rules.
- (2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed in the venue where the House of Delegates meets. Announcements sent by candidates to members of the House are considered campaigning and are specifically prohibited prior to the start of active campaigning. The Speakers may use additional means to make delegates aware of those members intending to seek election .
- (3) Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website as per Policy G-610.020, paragraph 2. Following each meeting, an "Official Candidate Notification" will be sent electronically to the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out following the April Board meeting and on "Official Announcement Dates" to be established by the Speaker.
- (4) Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on any council or the Board of Trustees, at any time by submitting an announcement card to the House Office. They will then be included in all subsequent projections of announcements before the House, "Official Candidate Notifications," and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Announcement Date. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times.

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

(6) If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (ie., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled position/s would remain unfilled until the next annual meeting.

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

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

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

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

(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker). Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individual's contact information to the Office of House of Delegates Affairs. The Speaker's Office will collect contact information for groups wishing to conduct interviews as well as for candidates and their campaign teams and will provide the information as requested.

(12) Interviews conducted with current candidates must comply with the following rules:

- a. Interviews may be arranged between the parties once active campaigning is allowed.
- b. Groups conducting interviews with candidates for a given office must offer an interview to all individuals that have officially announced their candidacy at the time the group's interview schedule is finalized.

- i. A group may meet with a candidate who is a member of their group without interviewing other candidates for the same office.
 - ii. Interviewing groups may, but are not required to, interview late announcing candidates. Should an interview be offered to a late candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.
 - iii. Any appearance by a candidate before an organized meeting of a caucus or delegation, other than their own, will be considered an interview and fall under the rules for interviews.
 - c. Groups may elect to conduct interviews virtually or in-person.
 - d. In-person interviews may be conducted between Friday and Monday of the meeting at which elections will take place.
 - e. Virtual interviews are subject to the following constraints:
 - i. Interviews may be conducted only during a window beginning on the Thursday evening two weeks prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place and must be concluded by that Sunday (four days later).
 - ii. Interviews conducted on weeknights must be scheduled between 5 pm and 10 pm or on weekends between 8 am and 10 pm based on the candidate's local time, unless another mutually acceptable time outside these hours is arranged.
 - iii. Caucuses and delegations scheduling interviews for candidates within the parameters above must offer alternatives to those candidates who have conflicts with the scheduled time.
 - f. Recording of interviews is allowed only with the knowledge and consent of the candidate.
 - g. Recordings of interviews may be shared only among members of the group conducting the interview.
 - h. A candidate is free to decline any interview request.
 - i. In consultation with the Election Committee, the Speaker, or where the Speaker is in a contested election, the Vice Speaker, may issue special rules for interviews to address unexpected situations.
- (13) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities.
- (14) Campaign memorabilia may not be distributed in the Not for Official Business (NFOB) bag.
- (15) Campaign materials may not be distributed by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will no longer furnish a file containing the names and mailing addresses of members of the AMA-HOD. Printed campaign materials will not be included in the "Not for Official Business" bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials.
- (16) A reduction in the volume of telephone calls and electronic communication from candidates and on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages.
- (17) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign memorabilia and giveaways that include a candidate's name or likeness may not be distributed at any time.
- (18) Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed.
- (19) At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited. It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate's opinions and positions on issues.

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

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

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

(23) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates.

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

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

Citation: CLRPD Rep. E, I-80; Res. 22, I-81; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: CLRPD Rep. F, I-91; CCRC Special Report, I-92; CCRC Special Report I-93; Special Committee on Campaign and Elections and Reaffirmed Special Committee Report on Campaigns and Elections, I-96; Special Committee on Campaigns and Elections, A-97; Reaffirmed: Sunset Report, I-00; Consolidated: CLRPD Rep. 3, I-01; CC&B Rep. 3, I-08; Modified: Rules and Credentials Rep. 1, A-11; Modified: Rules and Credentials Rep. 1, I-13; Appended: BOT Rep. 5, I-13; Modified: Res. 602, A-14; Modified: Speakers Rep. 1, I-14; Modified: Res. 1, A-15; Modified: Speakers Rep. 2, A-21; Modified: Speakers Rep. 1, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 615
(A-22)

Introduced by: Medical Student Section

Subject: Anti-Harassment Training

Referred to: Reference Committee F

1 Whereas, The 2018 National Academies of Science, Engineering, and Medicine (NASEM)
2 report on sexual harassment in academia defines sexual harassment as “composed of three
3 categories of behavior: (1) gender harassment (verbal and nonverbal behaviors that convey
4 hostility, objectification, exclusion, or second-class status about members of one gender), (2)
5 unwanted sexual attention (verbal or physical unwelcome sexual advances, which can include
6 assault), and (3) sexual coercion (when favorable professional or educational treatment is
7 conditioned on sexual activity)”, whether directly targeted towards an individual or ambient¹; and
8

9 Whereas, Gender-based discrimination and bias are widespread in the medical professional
10 workspace, with the rate of sexual harassment in academic medicine being close to double that
11 of other engineering and science fields^{2,3}; and
12

13 Whereas, Among female trainees, approximately 45% experience at least one instance of
14 gender harassment through sexist hostility, and 18% have experienced crude, sexist behavior,
15 and male trainees report 21% and 10% rates respectively¹; and
16

17 Whereas, The 2018 NASEM report concludes that “the cumulative effect of sexual harassment
18 is a significant and costly loss of talent in academic science, engineering, and medicine,
19 which has consequences for advancing the nation’s economic and social well-being and its
20 overall public health”¹; and
21

22 Whereas, Victims of sexual harassment often will not report the harassment to their institutions
23 because of fear of retaliation such as being “labeled as a troublemaker”⁴; and
24

25 Whereas, The U.S. Supreme Court recognizes claims for sexual harassment as a form of
26 discrimination based on sex under Title VII of the Civil Rights Act of 1964⁵; and
27

28 Whereas, The Equal Employment Opportunity Commission’s Select Task Force on the Study of
29 Harassment in the Workplace formed by the U.S. Equal Opportunity Employment Commission
30 in their executive report stated: “The importance of leadership cannot be overstated – effective
31 harassment prevention efforts, and workplace culture in which harassment is not tolerated, must
32 start with and involve the highest level of management of the company”⁶; and
33

34 Whereas, *Sexual Harassment of Women: Climate, Culture and Consequences in Academic*
35 *Science, Engineering and Medicine* states that “organizational tolerance for sexually harassing
36 behavior” increases the risk of sexual harassment occurring within the organization¹; and
37

38 Whereas, Sexual harassment in the professional environment leads to a well-documented loss
39 of productivity and attrition of workers^{1,7,8}; and

1 Whereas, A study published in *Academic Medicine* stated that it is imperative to have senior
2 faculty and leadership call out inappropriate behaviors and sexual harassment to serve as role
3 models for their colleagues, trainees, and staff⁴; and
4

5 Whereas, The American Association of Medical Colleges (AAMC) encourages a culture change
6 as a way to address harassment, which includes training individuals of all genders in bystander
7 intervention³; and
8

9 Whereas, Real-world and experimental evidence shows that the way leadership communicates
10 about sexual assault and sexual harassment strongly influences an organization or group's
11 attitudes toward sexual harassment and violence, with leadership emphasis on addressing
12 sexual harassment resulting in group participants rating the priority of addressing harassment
13 higher^{9,10,11}; and
14

15 Whereas, Among those who do report sexual harassment to their employers, nearly half report
16 being dissatisfied with the response¹²; and
17

18 Whereas, Given that the result of sexual harassment is a net loss of talent and highly trained
19 personnel, the costs of not aggressively addressing sexual harassment in medicine and
20 organized medicine are substantial¹; and
21

22 Whereas, Our AMA has a zero-tolerance policy for sexual harassment and expects members to
23 act with decorum at meetings according to the Code of Conduct (H-140.837) and the AMA Code
24 of Medical Ethics (9.1.3) explicitly states that sexual harassment is unethical, however there is
25 no formal training in the AMA on how to prevent/counter sexual harassment or advise members
26 when it occurs;¹³ and
27

28 Whereas, Our AMA has demonstrated a financial commitment to reducing sexual harassment
29 through previously utilizing outside resources to strengthen our AMA's policies and protections
30 of all AMA members¹⁴; and
31

32 Whereas, Our AMA has created a Continuing Medical Education module to address sexual
33 harassment in medicine, especially between physicians and their patients¹⁵; therefore be it
34

35 RESOLVED, That our American Medical Association require all members elected and
36 appointed to national and regional AMA leadership positions to complete AMA Code of Conduct
37 and anti-harassment training, with continued evaluation of the training for effectiveness in
38 reducing harassment within the AMA (Directive to Take Action); and be it further
39

40 RESOLVED, That our AMA work with the Women Physician Section, American Medical
41 Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other
42 stakeholders to identify an appropriate, evidence-based anti-harassment and sexual
43 harassment prevention training to administer to leadership. (Directive to Take Action)

Fiscal Note: Estimated cost to implement resolution is \$60K - \$65K.

Received: 05/11/22

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RELEVANT AMA POLICY**Policy on Conduct at AMA Meetings and Events H-140.837**

It is the policy of the American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.

Any type of harassment of any attendee of an AMA hosted meeting, event and other activity, including but not limited to dinners, receptions and social gatherings held in conjunction with an AMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA business is conducted. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an “AMA Entity”), as well as other AMA-sponsored events. The purpose of the policy is to protect participants in AMA-sponsored events from harm.

Definition

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact. Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

Operational Guidelines

The AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following:

1. Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)

The Office of General Counsel will appoint a "Conduct Liaison" for all AMA House of Delegates meetings and all other AMA hosted meetings or activities (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports of alleged policy violations, conducting investigations, and initiating both immediate and longer-term consequences for such violations. The Conduct Liaison appointed for any meeting will have the appropriate training and experience to serve in this capacity, and may be a third party or an in-house AMA resource with assigned responsibility for this role. The Conduct Liaison will be (i) on-site at all House of Delegates meetings and other large, national AMA meetings and (ii) on call for smaller meetings and activities. Appointments of the Conduct Liaison for each meeting shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in investigation of alleged policy violations and in decisions on consequences for policy violations.

The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA). The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.

2. Reporting Violations of the Policy

Any persons who believe they have experienced or witnessed conduct in violation of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," during any AMA House of Delegates meeting or other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel or JAMA Editorial Boards) should promptly notify the (i) Conduct Liaison appointed for such meeting, and/or (ii) the AMA Office of General Counsel and/or (iii) the presiding officer(s) of such meeting or activity.

Alternatively, violations may be reported using an AMA reporting hotline (telephone and online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will provide an option to report anonymously, in which case the name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the Conduct Liaison may investigate. These reporting mechanisms will be publicized to ensure awareness.

3. Investigations

All reported violations of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," pursuant to Section 2 above (irrespective of the reporting mechanism used) will be investigated by the Conduct Liaison. Each reported violation will be promptly and thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event to provide recommendations for action to the CCAM. Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator. Based on this investigation, the Conduct Liaison will determine whether a violation of the Policy on Conduct at AMA Meetings and Events has occurred.

All reported violations of the Policy on Conduct at AMA Meetings and Events, and the outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the AMA's Office of General Counsel (i.e. irrespective of whether the Conduct Liaison determines that a violation has occurred).

4. Disciplinary Action

If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison may take immediate action to protect the safety of event participants, which may include having the violator removed from the AMA meeting, event or activity, without warning or refund.

Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall report any such violation to the CCAM, together with recommendations as to whether additional commensurate disciplinary and/or corrective actions (beyond those taken on-site at the meeting, event or activity, if any) are appropriate.

The CCAM will review all incident reports, perform further investigation (if needed) and recommend to the Office of General Counsel any additional commensurate disciplinary and/or corrective action, which may include but is not limited to the following:

- Prohibiting the violator from attending future AMA events or activities;
- Removing the violator from leadership or other roles in AMA activities;
- Prohibiting the violator from assuming a leadership or other role in future AMA activities;
- Notifying the violator's employer and/or sponsoring organization of the actions taken by AMA;
- Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action;
- Referral to law enforcement.

The CCAM may, but is not required to, confer with the presiding officer(s) of applicable events activities in making its recommendations as to disciplinary and/or corrective actions. Consequence for policy violations will be commensurate with the nature of the violation(s).

5. Confidentiality

All proceedings of the CCAM should be kept as confidential as practicable. Reports, investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and Events will be kept confidential to the fullest extent possible, consistent with usual business practices.

6. Assent to Policy

As a condition of attending and participating in any meeting of the House of Delegates, or any council, section, or other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or activity, each attendee will be required to acknowledge and accept (i) AMA policies concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication and disciplinary processes for violations of such policies (including those implemented pursuant to these Operational Guidelines), and all attendees are expected to conduct themselves in accordance with these policies.

Additionally, individuals elected or appointed to a leadership role in the AMA or its affiliates will be required to acknowledge and accept the Policy on Conduct at AMA Meetings and Events and these Operational Guidelines.

[Editor's note: Violations of this Policy on Conduct at AMA Meetings and Events may be reported at 800.398.1496 or online at <https://www.lighthouse-services.com/ama>. Both are available 24 hours a day, 7 days a week.

Please note that situations unrelated to this Policy on Conduct at AMA Meetings and Events should not be reported here. In particular, patient concerns about a physician should be reported to the state medical board or other appropriate authority.]

BOT Rep. 23, A-17; Appended: BOT Rep. 20, A-18; Modified: BOT Rep. 10, A-19; Modified: CCB Rep. 2, I-20

9.1.3 Sexual Harassment in the Practice of Medicine

Sexual harassment can be defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

Sexual harassment in the practice of medicine is unethical. Sexual harassment exploits inequalities in status and power, abuses the rights and trust of those who are subjected to such conduct; interferes with an individual's work performance, and may influence or be perceived as influencing professional advancement in a manner unrelated to clinical or academic performance harm professional working relationships, and create an intimidating or hostile work environment; and is likely to jeopardize patient care. Sexual relationships between medical supervisors and trainees are not acceptable, even if consensual. The supervisory role should be eliminated if the parties wish to pursue their relationship.

Physicians should promote and adhere to strict sexual harassment policies in medical workplaces. Physicians who participate in grievance committees should be broadly representative with respect to gender identity or sexual orientation, profession, and employment status, have the power to enforce harassment policies, and be accessible to the persons they are meant to serve.

AMA Principles of Medical Ethics: II, IV, VII

Advancing Gender Equity in Medicine D-65.989

1. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.
2. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.
3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.
4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

Res. 010, A-18; Modified: BOT Rep. 27, A-19

Decreasing Sex and Gender Disparities in Health Outcomes H-410.946

Our AMA: (1) supports the use of decision support tools that aim to mitigate gender bias in diagnosis and treatment; and (2) encourages the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes.

Res. 005, A-18

AMA Sponsored Leadership Training for Hospital Medical Staff Officers and Committee Chairs H-225.972

It is the policy of the AMA (1) to offer, both regionally and locally, extensive training and skill development for emerging medical staff leaders to assure that they can effectively perform the duties and responsibilities associated with medical staff self-governance; and (2) that training and skill development programs for medical staff leaders be as financially self-supporting as feasible.

Res. 808, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: CMS Rep. 1, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 616
(A-22)

Introduced by: Medical Student Section

Subject: Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections

Referred to: Reference Committee F

1 Whereas, Over 90% of physicians surveyed in 2006 rated political involvement and collective
2 advocacy as important¹; and
3

4 Whereas, Civic engagement from medical professionals has been identified to improve
5 medicine's relationship with society²⁻⁴; and
6

7 Whereas, Voting is a constitutional right and is considered the most basic expression of civic
8 participation, and voting has been shown to have a relationship with other civic behaviors, even
9 suggesting a causative relationship between voting and civic engagement^{5,6}; and
10

11 Whereas, National physician voter registration rates have been documented as high as 94%,
12 and a study of residents and fellows suggests that up to 88% may be registered to vote^{7,8}; and
13

14 Whereas, Despite high rates of registration, physician voter turnout suggests physicians vote at
15 a rate lower than that of the general population and much lower than that of other white-collar
16 professions, with physicians' 22% turnout being lower than that of lawyers⁹; and
17

18 Whereas, Among the general public, such as statewide portable voter registration, which can
19 increase voter turnout by 2.4%; election day registration, which can increase voter turnout by 3-
20 6%; and the institution of mail-in ballots, which resulted in a 10% increase in voter turnout in
21 Oregon in both presidential and midterm elections¹⁰⁻¹²; and
22

23 Whereas, In a survey of residents and fellows, 94% agreed that they had the duty to advocate,
24 yet only 13% felt comfortable influencing legislation on a particular legislative issue⁸; and
25

26 Whereas, Medical students are eager to participate in the political process and view addressing
27 healthcare policy as a professional responsibility¹³; and
28

29 Whereas, Medical student voter participation has the potential to be highly influential on the
30 future of healthcare in our society and it is important to allot the time needed for engagement in
31 important historic events¹³; and
32

33 Whereas, Voter turnout is dependent on ability and ease of voting and conflicting work or school
34 schedule is consistently one of the top reasons registered nonvoters report for not voting¹⁴⁻¹⁶;
35 and
36

37 Whereas, Many medical students feel that their schools do not adequately allocate time for
38 students to vote and participate in the political process¹⁷; and

Whereas, AMA policy grants time off for resident involvement in organized medicine (H-310.911) and supports education of medical trainees on health policy, advocacy, and legislative issues that affect medical trainees and physicians (H-295.953), but does not address barriers that prevent medical students from voting; and

Whereas, The AMA endorses identifying efforts to engage physicians and medical trainees in legislative advocacy (G-615.103), the physician and medical trainee's right to engage in patient advocacy (H-285.910, H-225.950), as well as the fundamental importance of advocacy in the physician-patient relationship (H-225.950), yet no efforts are focused on identifying and alleviating barriers to medical student, resident/fellow, and physician voting; therefore be it

RESOLVED, That our American Medical Association study the rate of voter turnout in physicians, residents, fellows, and medical students in federal, state, and local elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community (Directive to Take Action); and be it further

RESOLVED, That our AMA work with appropriate stakeholders to guarantee a full day off on Election Days at medical schools. (Directive to Take Action)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy G-615.103

Our AMA will: (1) study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy; (2) study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy; and (3) identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy.

Res. 608, A-17

The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community H-285.910

Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:

Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community

In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of his/her rights under this paragraph.

Res. 8, A-11, Reaffirmed: CEJA Rep. 1, A-21

ACGME Allotted Time Off for Health Care Advocacy and Health Policy Activities H-310.911

Our AMA: 1) urges the Accreditation Council for Graduate Medical Education (ACGME) to acknowledge that "activities in organized medicine" facilitate competency in professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice; 2) encourages residency and fellowship programs to support their residents and fellows in their involvement in and pursuit of leadership in organized medicine; and 3) encourages the ACGME and other regulatory bodies to adopt policy that resident and fellow physicians be allotted additional time, beyond scheduled vacation, for scholarly activity time and activities of organized medicine, including but not limited to, health care advocacy and health policy.

Res. 317, A-11; Reaffirmed: CME Rep. 1, A-21

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.

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.

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.

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. 7, A-19, Reaffirmed: CMS Rep. 11, A-19, Modified: BOT Rep. 13, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 617
(A-22)

Introduced by: Medical Student Section

Subject: Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA

Referred to: Reference Committee F

Whereas, Meeting attendance and participation is an important and impactful part of student participation in the AMA, allowing students to connect with colleagues and with physician leaders, and mentors, which helps students find ways to stay involved in their future careers; and

Whereas, Of indebted medical students, the mean educational debt of the medical school class of 2021 was \$203,062¹; and

Whereas, Cost is a significant barrier to student participation in the AMA's biannual meetings of the MSS and HOD, in which the AMA-MSS generally meets for two to three days prior to the House of Delegates (HOD) which meets for three or four additional days, with costs for the most recent in-person Annual and Interim HOD meetings as follows:

- Travel:
 - ~\$350-550 round-trip airfare for each A-19 and I-19 trips, individually.²
 - [Airport Transportation To/From Hotel 2019 HOD Meeting](#): \$35 One way; \$50 Two way.³
 - Hawaii-based meetings: ~\$670s-\$820s round-trip airfare.⁴
- Lodging:
 - 2019 Annual Meeting (Hyatt Regency in Chicago, IL):
 - Single: \$255 per night plus tax = \$299.34 per night
 - Double: \$280 per night plus tax = \$328.69 per night
 - 2019 Interim Meeting (Manchester Grand Hyatt and Marriott Marquis in San Diego, CA):
 - \$285 per night plus tax = \$321.28 per night.³
- Food:
 - 2019 Annual Meeting:
 - Chicago: \$34/day.⁶
 - [2019 Interim Meeting](#):
 - San Diego: \$33/day.⁵

Whereas, All medical students are encouraged to attend the AMA-MSS meeting, and at least one delegate and alternate delegate from every medical school is expected to be at the assembly, and the HOD assembly is attended by student representatives from each region based on total region membership, in addition to student councilors, a section delegate and alternate delegate (MSS Internal Operating Procedures 10.4 through 10.4.6; AMA Bylaws 2.3 through 2.3.6, 7.3.3 through 7.3.4.3), and MSS registrants at the A-19 MSS Meeting was 620 members and at the I-19 MSS Meeting was 711 members (data provided by staff); and

1 Whereas, In addition to the AMA-MSS Annual and Interim meetings, medical student members
2 may also participate in additional advocacy or region-specific conferences that require travel,
3 such as the AMA Medical Student Advocacy Conference (in Washington, DC) and Region-
4 specific Physicians of the Future Summits (held in various locations within each geographic
5 region); and
6

7 Whereas, Some MSS Regional Delegates and Alternate Regional Delegates to the HOD
8 receive financial support from their state delegations, but a 2022 survey of the MSS Caucus
9 showed that 51% of these delegates are receiving funding for travel and hotel, 12% for hotel
10 only, and 37% receive no state funding; and
11

12 Whereas, Many organizations provide funding for students to participate in their meetings, for
13 example:

- 14 • the American College of Radiology (ACR) offers up to 15 stipends of \$150 to qualified
15 medical students attending the ACR annual meeting when virtual⁷
- 16 • the American Academy of Family Physicians (AAFP) provides 250 scholarships of \$600
17 to attend their national conference^{8,9}
- 18 • the American Medical Women's Association (AMWA) gives scholarships to students and
19 has special consideration to students with leadership positions, presenting posters,
20 ambassadors, or who are traveling from far-away locations¹⁰
- 21 • the American Psychiatric Association (APA) provides up to 30 medical students variable
22 funding to attend both the Annual Meeting and the Mental Health Services Conference¹¹
23 and specifically seeks to support underrepresented minority and racial/ethnic students
- 24 • the Society for Vascular Surgery (SVS) and American Academy of Neurology (AAN) also
25 offer travel awards specifically focused on diverse student populations in addition to a
26 general award^{12,13}; and
27

28 Whereas, A study of the AAFP's funding mechanism and conference attendance demonstrated
29 that systematic programs to fund student participation in conferences increased attendance and
30 likelihood of future conference attendance⁹; and
31

32 Whereas, For general AMA-MSS members, until spring 2021 the sole AMA funding source for
33 travel was the Medical Student Outreach Program (MSOP) Recruitment Commission; MSOP is
34 a peer-to-peer mentorship initiative designed to promote first year medical student recruitment
35 and engagement and based on recruitment numbers from early April 2021, the average
36 Recruitment Commission per school would be around \$550; median around \$250^{14,15}; and
37

38 Whereas, In March 2021, the AMA announced a new travel scholarship, for up to \$1,000, for
39 one student from each MSS Region (seven students total), to be awarded for the first time for
40 the Annual 2022 Meeting, and as a part of the AMA Section Involvement Grant, MSOP
41 instituted an AMA Annual Meeting Travel Grant for students to attend the MSS June 2022
42 Meeting^{16,17}; and
43

44 Whereas, The AMA Ambassador Program provides leadership and networking opportunities for
45 MSS members, including scholarships to attend and be trained at AMA advocacy
46 conferences¹⁸; and
47

48 Whereas, Besides the data from the informal poll above, data on student funding for meetings
49 are not available, and likewise neither are data on financial or other barriers to student
50 participation in AMA meetings; and

Whereas, Our AMA is dedicated to the professional development of student, resident and fellow, and young physician section representatives (G-600.030); therefore be it

RESOLVED, That our American Medical Association explore mechanisms to mitigate costs associated with medical student participation at national, in-person AMA conferences. (Directive to Take Action)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Diversity of AMA Delegations G-600.030

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.

CCB/CLRPD Rep. 3, A-12

Diversity in the Physician Workforce and Access to Care D-200.982

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

CME Rep. 7, A-08; Reaffirmation A-13; Reaffirmation: A-16; Reaffirmed: 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.

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

Financial Aid to Medical Students H-305.999

Our AMA urges physicians to contribute to the AMA Foundation for support of medical education and provision of scholarships to medical students.

Res. 6, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20

AMA Bylaws**AMA Bylaws 2.3 through 2.3.6, 7.3.3 through 7.3.4.3**

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

2.3.1 Qualifications. Medical Student Regional delegates and alternate delegates must be active medical student members of the AMA.

2.3.2 Apportionment. The total number of Medical Student Regional delegates and alternate delegates is based on one delegate and one alternate delegate for each 2,000 active medical student members of the AMA, as recorded by the AMA on December 31 of each year. 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. Any remaining Medical Student Section Regional delegates and alternate delegates shall be apportioned one delegate and one alternate delegate per region(s) with the greatest number of active AMA medical student members in excess of a multiple of 2,000. If two regions have the same number of active AMA medical student members, ties will be broken by lottery by the MSS Governing Council.

2.3.2.1 Effective Date. In January of each year the AMA shall notify the Medical Student Section Governing Council of the number of seats in the House of Delegates to which each Medical Student Region is entitled. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.3.3 Election. Medical Student Regional delegates and alternate delegates shall be elected by the Medical Student Section in accordance with procedures adopted by the Section. Each elected delegate and alternate 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 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 Annual Meeting of the House of Delegates.

7.3.3 Representatives to the Business Meeting.

7.3.3.1 Representatives. The AMA medical student members of each educational program as defined in Bylaw 1.1.1 may select one representative and one alternate representative. An educational program as defined in Bylaw 1.1.1 that has a total student population (excluding students at associated administrative campuses) greater than 999 may select one additional representative and one additional alternate representative.

7.3.3.2 Medical School Separate Campus. The AMA medical student members of an educational program as defined in Bylaw 1.1.1 that has more than one campus may select a representative and an alternate representative from each campus. A separate campus is defined as an administrative campus separate from the central campus where a minimum of 20 members of the medical student body are assigned for some portion of their instruction over a period of time not less than an academic year. The Governing Council shall establish appropriate rules, subject to approval of the Board of Trustees, for credentialing all representatives.

7.3.3.3 National Medical Specialty Societies, Federal Services, and Professional Interest Medical Associations. Each national medical specialty society, Federal Service, and professional interest medical association granted representation in the House of Delegates that has established a medical student component is entitled to one representative and one alternate representative selected by the medical student members of the organization. The Governing Council shall adopt uniform rules and criteria to determine if an organization represented in the House of Delegates has established a medical student membership component so as to qualify for representation at the Business Meeting. The procedure by which the medical student representative from the organization is selected must meet the requirements established by the Governing Council.

7.3.3.4 National Medical Student Organizations. National medical student organizations that have been granted representation in the Medical Student Section Business Meeting may select one representative and one alternate representative.

7.3.3.4.1 Criteria for Eligibility. National medical student organizations that meet the following criteria may be considered for representation in the Medical Student Section Business Meeting:

- a. The organization must be national in scope.
- b. A majority of the voting members of the organization must be medical students enrolled in educational programs as defined in Bylaw 1.1.1.
- c. Membership in the organization must be available to all medical students, without discrimination.

d. The purposes and objectives of the organization must be consistent with the AMA's purposes and objectives.

e. The organization's code of medical ethics must be consistent with the AMA's Principles of Medical Ethics.

7.3.3.4.2 Procedure. The Medical Student Section shall adopt appropriate rules for the application, acceptance and retention of national medical student organizations. Recommendations for acceptance and discontinuance shall be subject to the approval of the Board of Trustees.

7.3.3.4.3 Rights and Responsibilities. The medical student representative of each national medical student organization granted representation in the Business Meeting shall have full voting rights, including the right to vote in any elections at the conclusion of a 2-year probationary period with regular attendance. The representatives shall not be eligible for election to any office in the Medical Student Section.

7.3.3.5 Other Groups. The Association of American Medical Colleges – Organization of Student Representatives and the American Association of Colleges of Osteopathic Medicine – Council of Osteopathic Student Government Presidents are each entitled to one representative and one alternate representative selected by the medical student members of the organization. The procedure by which the medical student representative from each of these groups is selected must meet the requirements established by the Governing Council.

7.3.3.6 Certification. All representatives to the Business Meeting must be medical student members of the AMA and shall be properly certified to the Governing Council in accordance with rules established by the Governing Council.

7.3.4 Additional Purposes of the Meeting. In addition to the purposes of the Business Meeting set forth in Bylaw 7.0.6.1, the purposes of the meeting shall include:

7.3.4.1 To elect the medical student trustee at the Business Meeting prior to the Interim Meeting of the AMA.

7.3.4.2 To adopt procedures for election of Medical Student Regional delegates and alternate delegates established in Bylaw 2.3.

7.3.4.3 To elect Medical Student Regional delegates and alternate delegates at the business meeting prior to the Interim Meeting of the AMA. Elected delegates and alternate delegates shall be seated at the Annual Meeting of the House of Delegates.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 618
(A-22)

Introduced by: Oklahoma

Subject: Extending the Delegate Apportionment Freeze During COVID-19 Pandemic

Referred to: Reference Committee F

Whereas, The COVID-19 pandemic has been difficult for physicians and the practice of medicine; many physicians have elected not to renew their memberships in organized medicine due to numerous reasons; and

Whereas, 40% of the Oklahoma State Medical Association active dues paying members in 2021 and 36% in 2022 took a self-determined 50% dues reduction for the COVID-19 hardship; and

Whereas, Because of the COVID-19 pandemic, many state and specialty associations have not been able to meet in person to utilize their usual platforms to promote the importance of organized medicine; and

Whereas, At the November 2020 Special Meeting, the House of Delegates asked that our AMA extend the current grace period from one year to two years for losing a delegate from a state medical or national medical specialty society until the end of 2022; and

Whereas, The “freeze” adopted at November 2020 meeting proved to benefit 22 states, Alabama, Arkansas, California, Colorado, District of Columbia, Florida, Hawaii, Illinois, Kansas, Massachusetts, Michigan, Minnesota, Missouri, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Virginia, and Washington(1); and

Whereas, The current freeze has left the overall size of the House of Delegates unchanged and will seat 693 delegates during 2022(2); and

Whereas, Many states and specialty societies have continued to have decreased AMA membership; therefore be it

RESOLVED, That our American Medical Association extend the current delegate apportionment freeze for losing a delegate from a state medical or specialty society until the end of 2023.
(Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 05/11/22

References

1. <https://www.maq.org/wp-content/uploads/2021/05/2021-Delegate-Apportionment-States.pdf>
2. <https://www.ama-assn.org/system/files/2022-delegate-apportionment-memos.pdf>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 619
(A-22)

Introduced by: Texas, South Carolina, Florida, Mississippi, New Jersey, Pennsylvania

Subject: Focus and Priority for the AMA House of Delegates

Referred to: Reference Committee F

1 Whereas, The speakers of the American Medical Association House of Delegates established a
2 Resolutions Committee for the 2021 Special Meeting; and
3

4 Whereas, The Resolutions Committee will streamline and increase the efficiency of the
5 business of the house; and
6

7 Whereas, Resolution 605, Nov. 21, was referred to the Board of Trustees for study with a verbal
8 request for a report back at the 2022 Annual Meeting, and no report has been issued; and
9

10 Whereas, The number of resolutions submitted to our AMA continues to remain very high; and
11

12 Whereas, Our AMA needs to prioritize and focus to develop policy and act on the issues that
13 are pertinent and important to practicing physicians; that require urgent attention; on which our
14 AMA is the appropriate organization to lead; on which an AMA stance would have a positive
15 impact; that have not been considered previously and voted down; or about which good AMA
16 policy does not already exist; therefore be it
17

18 RESOLVED, That the Resolutions Committee be formed as a standing committee of the house,
19 the purpose of which is to review and prioritize all submitted resolutions to be acted upon at the
20 annual and interim meetings of the AMA House of Delegates (Directive to Take Action); and be
21 it further
22

23 RESOLVED, That the membership of the Resolutions Committee be composed of one Medical
24 Student Section (MSS) member, one Resident and Fellow Section (RFS) member, and one
25 Young Physicians Section (YPS) member, all appointed by the speakers through nominations of
26 the MSS, RFS, and YPS respectively; six regional members appointed by the speakers through
27 nominations from the regional caucuses; six specialty members appointed by the speakers
28 through nominations from the specialty caucuses; three section members appointed by the
29 speakers through nominations from sections other than the MSS, RFS, and YPS; and one past
30 president appointed by the speakers (Directive to Take Action); and be it further
31

32 RESOLVED, That the members of the Resolutions Committee serve staggered two-year terms
33 except for the past president and the MSS and RFS members, who shall serve a one-year term
34 (Directive to Take Action); and be it further
35

36 RESOLVED, That members of the Resolutions Committee cannot serve more than four years
37 consecutively (Directive to Take Action); and be it further

1 RESOLVED, That if a Resolutions Committee member is unable or unwilling to complete his or
2 her term, the speakers will replace that member with someone from a similar member group in
3 consultation with that group the next year, and the new member will complete the unfulfilled
4 term (Directive to Take Action); and be it further

5
6 RESOLVED, That each member of the Resolutions Committee confidentially rank resolutions
7 using a 0-to-5 scale (0 – not a priority to 5 – top priority) based on scope (the number of
8 physicians affected), urgency (the urgency of the resolution and the impact of not acting),
9 appropriateness (whether AMA is the appropriate organization to lead on the issue), efficacy
10 (whether an AMA stance would have a positive impact), history (whether the resolution has
11 been submitted previously and not accepted), and existing policy (whether an AMA policy
12 already effectively covers the issue). Resolutions would not have to meet all of these
13 parameters nor would these parameters have to be considered equally (Directive to Take
14 Action); and be it further

15
16 RESOLVED, That the composite (or average) score of all members of the Resolutions
17 Committee be used to numerically rank the proposed resolutions. No resolution with a
18 composite average score of less than 2 would be recommended for consideration. The
19 Resolutions Committee would further determine the cutoff score above which resolutions would
20 be considered by the house based on the available time for reference committee and house
21 discussion, and the list of resolutions ranked available for consideration would be titled
22 “Resolutions Recommended to be Heard by the HOD” (Directive to Take Action); and be it
23 further

24
25 RESOLVED, That the Resolutions Committee also make recommendations on all resolutions
26 submitted recommending reaffirmation of established AMA policy and create a list titled
27 “Resolutions Recommended for Reaffirmation,” with both lists presented to the house for
28 acceptance (Directive to Take Action); and be it further

29
30 RESOLVED, That the membership of the Resolutions Committee be published on the AMA
31 website with a notice that the appointed members should not be contacted, lobbied, or coerced;
32 any such activity must be reported to the AMA Grievance Committee for investigation; and
33 should the alleged violations be valid, disciplinary action of the offending person will follow
34 (Directive to Take Action); and be it further

35
36 RESOLVED, That the bylaws be amended to add the Resolution Committee as a standing
37 Committee with the defined charge, composition, and functions as defined above for all AMA
38 HOD meetings effective Interim 2022. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000 assuming the resolution committee would not convene in person.

Received: 05/09/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 620
(A-22)

Introduced by: Ohio

Subject: Review of Health Insurance Companies and Their Subsidiaries' Business Practices

Referred to: Reference Committee F

1 Whereas, In 2021 a jury awarded \$60 million in punitive damages to three Nevada-based
2 TeamHealth affiliates in their case against United Healthcare for unfair payment and
3 reimbursement tactics; and
4

5 Whereas, In 2008, Ingenix, a subsidiary of United Healthcare, reached a settlement of \$400
6 million due to knowingly using falsified data in order to cause physicians to be underpaid for
7 their services; and
8

9 Whereas, Our AMA was instrumental in exposing the 2008 fraudulent activity; therefore be it
10

11 RESOLVED, That our American Medical Association conduct a review of the business practices
12 of health insurance companies in order to identify potential fraudulent and unfair activities.
13 (Directive to Take Action)

Fiscal Note: Estimated cost to implement resolution is \$300K annually.

Received: 05/10/22