

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

172st ANNUAL MEETING CHICAGO, ILLINOIS June 9–13, 2022

CALL TO ORDER AND MISCELLANEOUS BUSINESS

CALL TO ORDER: The House of Delegates convened its 172nd Annual Meeting at 6 p.m. Friday, June 9, in the Grand Ballroom of the Hyatt Regency Chicago, Bruce A. Scott, MD, Speaker of the House of Delegates, presiding. The Saturday, June 10, Monday, June 12, and Tuesday, June 13, sessions also convened in the Grand Ballroom. The meeting adjourned following the Tuesday afternoon session.

INVOCATION: The following invocation was delivered by Rev. Dr. Marshall Elijah Hatch, Sr. Dr. Hatch has been the pastor of the New Mount Pilgrim Missionary Baptist Church located in the heart of Chicago's West Garfield community since 1993 and is a native of Chicago's West Side:

Dear God, we thank you for the great gift of life. We thank you for this day the call to serve. We thank you for the sacred mission of the American Medical Association, and this day we embrace the call to extend ourselves as members of the healing profession.

We pledge to serve...we pledge to help because we have been helped. And in spite of our own wounds, we embrace the call of wounded healers. Doing your work in the world, we acknowledge the painful legacy of dispossession of first nations and first people on this continent. We acknowledge the painful legacies of enslavement, exploitation, and dehumanization. With repentance we say the name Henrietta Lacks and countless of other enslaved women without agency used for medical research. We acknowledge the sacrifices of ancestors from all over the world who've come to this incomplete American project and imperfect union. And so let our work in the healing professions be a work of spiritual redemption.

Give a divine mandate to remember the poor, to remember those in the margins: the lost, the least, the left out. Whatever the ZIP Code, whatever the social status, whatever the walk of life that people come from into our care, we proclaim that all people have a right to health care. We yet hear the voice of that 20th Century prophet, Dr. Martin Luther King, Jr.: "Of all of the injustices among human community, disparities in access to health care are the most shocking and inhuman." We pledge to be healers who work for justice, and we will not rest until justice of access to healthcare rolls down like waters and righteousness like a mighty stream.

We proclaim this day the vision of beloved community, that when the interest of those in the margins, the most vulnerable are brought to the center of public policy, that's when God's kingdom arrives. And now we pray in the spirit of one with privilege who says, "As you've done unto the least of these you've done unto me."

And every heart said, Amen.

REPORTS OF THE COMMITTEE ON RULES AND CREDENTIALS: The following reports were presented by Roxanne Tyroch, MD, Chair:

CREDENTIALS: The Committee on Rules and Credentials reported that on Friday, June 9, 485 out of 705 delegates (68.7%) had been accredited, thus constituting a quorum; on Saturday, June 10, 608 delegates (86.2%) were present; on Monday, June 12, 669 (94.9%) were present at the start of the session and 669 of 708 delegates (94.9%) were present at the end of the session; on Tuesday, June 13, 684 (96.6%) were present.

Note: During Monday's business session, American Academy of Addiction Psychiatry, American Society for Aesthetic Plastic Surgery, and Society for Cardiovascular Magnetic Resonance were granted representation in the House of Delegates (see Board of Trustees Report 2), which increased the number of delegates seats to 708.

RULES REPORT - Friday, June 9**HOUSE ACTION: ADOPTED**

Your Committee on Rules and Credentials recommends:

1. House Security
Maximum security shall be maintained at all times to prevent disruptions of the House, and only those individuals who have been properly badged will be permitted to attend.
2. Credentials
The registration record of the Committee on Rules and Credentials shall constitute the official roll call at each meeting of the House.
3. Order of Business
The order of business as published in the Handbook shall be the official order of business for all sessions of the House of Delegates. This may be varied by the Speaker if, in his judgment, it will expedite the business of the House, subject to any objection sustained by the House.
4. Privilege of the Floor
The Speaker may grant the privilege of the floor to such persons as may be presented by the President, or Chair of the Board of Trustees, or others who may expedite the business of the House, subject to objections sustained by the House.
5. Procedures of the House of Delegates
The June 2023 edition of the "House of Delegates Reference Manual: Procedures, Policies and Practices" shall be the official method of procedure in handling and conducting the business before the AMA House of Delegates.
6. Reference Committee Appointments
As per bylaw 2.13.1.3 and 2.13.1.4, the Speaker shall appoint the Chair and six (6) other members of each reference committee. Membership on reference committees is restricted to delegates and alternate delegates. Notwithstanding the House of Delegates Reference Manual: Procedures, Policies and Practices, for this meeting there will be no limitation on the number of alternate delegates allowed to serve on each reference committee.
7. Limitation on Debate
There will be a 90 second limitation on debate per presentation subject to waiver by the Speaker for just cause.
8. Nominations and Elections
The House will receive nominations for President-Elect, Speaker, Vice Speaker, Trustees and Council Members during the Opening Session of the House of Delegates on Friday evening, June 9. Once nominations are closed there shall be no further nominations. All nominated candidates for any open or potentially open position will be included on the ballot unless they specifically ask for their name to be withdrawn from nomination. Officer candidates in contested elections will give speeches during the Opening Session of the House. The order of speeches will be selected by lottery.
9. The Association's 2023 annual election balloting shall be held Tuesday, June 13 from 8:30 to 9:00 am during an Election Session. Only credentialed delegates will be allowed in the delegate seating area. Elections will be held sequentially with president-elect first, followed by other officers and then councils in alphabetical order.
10. In instances where there is only one nominee for an office, a majority vote without ballot shall elect on Friday.

11. Conflict of Interest

Members of the House of Delegates who have an interest that is or may be material to the matter being considered and that would reasonably be expected to impair the objectivity of the individual who is testifying, must publicly disclose that interest immediately prior to testifying at a reference committee on the matter or speaking on the floor of the House of Delegates on the matter.

12. Conduct of Business by the House of Delegates

Each member of the House of Delegates and the AMA Officers resolutely affirm a commitment to abide by our AMA Code of Conduct.

13. Respectful Behavior

Courteous, collegial, and respectful behavior in all interactions with others, including delegates, is expected of all attendees at House of Delegates meetings, including social events apart from House of Delegates meetings themselves.

SUPPLEMENTARY REPORT - Saturday, June 10**HOUSE ACTION: ADOPTED AS FOLLOWS****LATE RESOLUTION 1001 ACCEPTED****LATE RESOLUTIONS 1002, 1003 AND 1004 NOT ACCEPTED****EXISTING POLICY REAFFIRMED IN LIEU OF RESOLUTIONS 111, 114, 115, 229, 232, 233, 238, 242, 243, 248, 249, 250, 252, 253, 317, 523, 524 and 717.****(1) LATE RESOLUTION**

The Committee on Rules and Credentials met Friday, June 9, to discuss Late Resolution 1001, 1002, 1003, and 1004. The sponsor of the late resolution met with the committee and was given the opportunity to present for the committee's consideration the reason the resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting.

Recommended for acceptance:

- Late 1001 – Prediabetes as a Major Health Concern for Chronic Disease Prevention

Recommended not be accepted:

- Late 1002 – Withdraw and Amend Virtual Credit Card Policy
- Late 1003 – Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion
- Late 1004 – Treatment of Overweight and Obesity

(2) REAFFIRMATION RESOLUTIONS

The Speakers asked the Committee on Rules and Credentials to review the recommendations for placing resolutions introduced at this meeting of the House of Delegates on the Reaffirmation Calendar. Reaffirmation of existing policy means that the policies reaffirmed remain active policies within the AMA policy database and therefore are part of the body of policy that can be used in setting the AMA's agenda. It also resets the sunset clock, so such policies will remain viable for 10 years from the date of reaffirmation. The Committee recommends that current policy be reaffirmed in lieu of the following resolutions (current policy and AMA activities are listed in the Appendix to this report):

- Resolution 005 – Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees
- Resolution 102 – Reforming the Medicare Part B “Buy and Bill” Process to Encourage Biosimilar Use
- Resolution 103 – Movement Away from Employer-Sponsored Health Insurance

- Resolution 104 – Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment
- Resolution 105 – Studying Population-Based Payment Policy Disparities
- Resolution 108 – Sustainable Reimbursement for Community Practices
- Resolution 109 – Improved Access to Care for Patients in Custody of Protective Services
- Resolution 110 – Long-Term Care Coverage for Dementia Patients
- Resolution 111 – Potential Negative Consequences of ACOs
- Resolution 112 – Removal of Barriers to Care for Lung Cancer Screening in Medicaid
- Resolution 113 – Cost of Insulin
- Resolution 114 – Physician and Trainee Literacy of Healthcare Costs
- Resolution 115 – Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer
- Resolution 116 – Medicare Coverage of OTC Nicotine Replacement Therapy
- Resolution 117 – Payment for Physicians Who Practice Street Medicine
- Resolution 201 – Pharmacists Prescribing for Urinary Tract Infections
- Resolution 207 – Ground Ambulance Services and Surprise Billing
- Resolution 210 – The Health Care Related Effects of Recent Changes to the US Mexico
- Resolution 212 – Marijuana Product Safety
- Resolution 213 – Telemedicine Services and Health Equity
- Resolution 214 – Advocacy and Action for a Sustainable Medical Care System
- Resolution 218 – Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners
- Resolution 219 – Repealing the Ban on Physician-Owned Hospitals
- Resolution 220 – Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations
- Resolution 222 – Physician Ownership of Hospital Blocked by the ACA
- Resolution 223 – Protecting Access to Gender Affirming Care
- Resolution 224 – Advocacy Against Obesity-Related Bias by Insurance Providers
- Resolution 227 – Reimbursement for Postpartum Depression Prevention
- Resolution 229 – Firearm Regulation for Persons Charged with or Convicted of a Violent Offense
- Resolution 231 – Equitable Interpreter Services and Fair Reimbursement
- Resolution 232 – Supervised Injection Facilities (SIFs) Allowed by Federal Law
- Resolution 233 – Dobbs-EMTALA Medical Emergency
- Resolution 234 – Medicare Physician Fee Schedule Updates and Grassroots Campaign
- Resolution 238 – Eliminate Mandatory Medicare Budget Cuts
- Resolution 242 – Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting
- Resolution 243 - Replacing the Frye Standard for the Daubert Standard in Expert Witness
- Resolution 244 – Recidivism
- Resolution 245 – Biosimilar Interchangeable Terminology
- Resolution 246 – Modification of CMS Interpretation of Stark Law
- Resolution 248 – Supervised Consumption Sites
- Resolution 249 – Restrictions on Social Media Promotion of Drugs
- Resolution 250 – Medicare Budget Neutrality
- Resolution 252 – Strengthening Patient Privacy
- Resolution 253 – Appropriate Compensation for Non-Visit Care (Remote or Care of
- Resolution 254 – Eliminating the Party Statement Exception in Quality Assurance Proceedings
- Resolution 313 – Filtering International Medical Graduates During Residency or Fellowship Applications
- Resolution 315 – Prohibit Discriminatory ERAS® Filters In NRMP Match
- Resolution 317 – Supporting Childcare for Medical Resident
- Resolution 425 – Examining Policing Through a Public Health Lens
- Resolution 426 – Accurate Abortion Reporting with Demographics by the Center for Disease Control
- Resolution 431 - Qualified Immunity Reform
- Resolution 510 – Comparative Effectiveness Research
- Resolution 515 – Regulate Kratom and Ban Over-The-Counter Sales
- Resolution 516 – Fasting is Not Required for Lipid Analysis
- Resolution 522 – Approval Authority of the FDA
- Resolution 523 – Reducing Youth Abuse of Dextromethorphan

- Resolution 524 – Ensuring Access to Reproductive Health Services Medications
- Resolution 701 – Reconsideration of the Birthday Rule
- Resolution 702 – Providing Reduced Parking for Patients
- Resolution 703 – Tribal Health Program Electronic Health Record Modernization
- Resolution 705 – Aging and Dementia Friendly Health Systems
- Resolution 711 – Doctors’ Risk for Termination of Liability Coverage or Medical Privileges Consequent to Dobbs
- Resolution 713 – Redesigning the Medicare Hospice Benefit
- Resolution 714 – Improving Hospice Program Integrity
- Resolution 715 – Published Metrics for Hospitals and Hospital Systems
- Resolution 716 – Transparency and Accountability of Hospitals and Hospital Systems
- Resolution 717 – Improving Patient Access to Supplemental Oxygen Therapies
- Resolution 718 – Insurance Coverage of FDA Approved Medications and Devices
- Resolution 722 – Expanding Protections of End-of-Life Care
- Resolution 723 – Vertical Consolidation in Health Care – Markets or Monopolies

APPENDIX

Resolution 005 – Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees

- Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism H-65.949
- Support of Human Rights and Freedom H-65.965
- Civil Rights & Medical Professionals E-9.5.4
- Hospital Dress Codes for the Reduction of Health Care-Associated Infection Transmission of Disease H-440.856

Resolution 102 – Reforming the Medicare Part B “Buy and Bill” Process to Encourage Biosimilar Use

- Cuts in Medicare Outpatient Infusion Services D-330.960
- Pharmaceutical Costs H-110.987
- Biosimilar Interchangeability Pathway H-125.976
- Abbreviated Pathway for Biosimilar Approval H-125.980
- Reference Pricing H-185.935
- Medicare Reimbursements for Medications H-330.917

Resolution 103 – Movement Away from Employer-Sponsored Health Insurance

- Options to Maximize Coverage under the AMA Proposal for Reform H-165.823
- Health Insurance Affordability H-165.828
- Individual Health Insurance H-165.920

Resolution 104 – Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment

- Health Care for Older Patients H-25.999
- Support for Housing Modification Policies H-160.890

Resolution 105 – Studying Population-Based Payment Policy Disparities

- Planning and Delivery of Health Care Services H-160.975
- US Physician Shortage H-200.954
- Principles of and Actions to Address Primary Care Workforce H-200.949
- Access to Care by Medicaid Patients H-290.989

Resolution 108 – Sustainable Reimbursement for Community Practices

- The Preservation of the Private Practice of Medicine D-405.988
- Enhanced SCHIP Enrollment, Outreach, and Reimbursement H-290.976
- Health Care Access for Medicaid Patients H-385.921
- Physician Payment Reform H-390.849

Resolution 109 – Improved Access to Care for Patients in Custody of Protective Services

- Alternative Payment Models and Vulnerable Populations D-385.952
- Health Plan Initiatives Addressing Social Determinants of Health H-165.822
- Medicaid - Towards Reforming the Program H-290.997
- Improving Risk Adjustment in Alternative Payment Models H-385.907

Resolution 110 – Long-Term Care Coverage for Dementia Patients

- Senior Care H-25.993
- Financing of Long-Term Services and Supports H-280.945
- Promoting and Ensuring Safe, High Quality, and Affordable Elder Care Through Examining and Advocating for Better Regulation of and Alternatives to the Current, Growing For-Profit Long Term Care Options D-280.982
- Ensuring Medicare Coverage for Long Term Care D-280.985
- Policy Directions for the Financing of Long-Term Care H-280.991

Resolution 111 – Potential Negative Consequences of ACOs

- Health Care Reform Physician Payment Models D-385.963
- Accountable Care Organization Principles H-160.915
- Physician-Focused Alternative Payment Models H-385.913
- Alternative Payment Models and Vulnerable Populations D-385.952
- Improving Risk Adjustment in Alternative Payment Models H-385.907
- Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk) D-385.953
- Prospective Payment Model Best Practices for Independent Private Practice H-385.904

Resolution 112 – Removal of Barriers to Care for Lung Cancer Screening in Medicaid

- Lung Cancer Screening to be Considered Standard Care H-185.936

Resolution 113 – Cost of Insulin

- Insulin Affordability H-110.984
- Incorporating Value into Pharmaceutical Pricing H-110.986
- Pharmaceutical Costs H-110.987
- Cost Sharing Arrangements for Prescription Drugs H-110.990
- Strategies to Address Rising Health Care Costs H-155.960

Resolution 114 – Physician and Trainee Literacy of Healthcare Costs

- Controlling Cost of Medical Care H-155.966
- Price Transparency D-155.987
- Management and Leadership for Physicians D-295.316
- Patient Information and Choice H-373.998

Resolution 115 – Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer

- Symptomatic and Supportive Care for Patients with Cancer H-55.999
- Health Insurance Market Regulation H-165.856
- Status Report on the Uninsured H-185.964

Resolution 116 – Medicare Coverage of OTC Nicotine Replacement Therapy

- Health Plan Coverage for Over-the-Counter Drugs H-185.956
- Health Insurance and Reimbursement for Tobacco Cessation and Counseling H-490.916

Resolution 117 – Payment for Physicians Who Practice Street Medicine

- Eradicating Homelessness H-160.903

Resolution 201 – Pharmacists Prescribing for Urinary Tract Infections

- Practicing Medicine by Non-Physicians H-160.949
- Evaluation of the Expanding Scope of Pharmacists' Practice D-35.987
- Drug Initiation or Modification by Pharmacists H-160.928
- Combating Antimicrobial Resistance through Education H-100.973

Resolution 207 – Ground Ambulance Services and Surprise Billing

- Out-of-Network Care H-285.904
- Billing Procedures for Emergency Care H-130.978
- Medicare Balance Billing D-390.986
- Balance Billing H-385.991

Resolution 210 – The Health Care Related Effects of Recent Changes to the US Mexico Border

- Immigration Status is a Public Health Issue D-350.975
- Patient and Physician Rights Regarding Immigration Status H-315.966
- Financial Impact of Immigration on the American Health System H-160.920
- Financial Impact of Immigration on American Health System D-160.988

Resolution 212 – Marijuana Product Safety

- Cannabis Legalization for Medicinal Use D-95.969
- Cannabis and Cannabinoid Research H-95.952
- Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924
- Cannabis Warnings for Pregnant and Breastfeeding Women H-95.936
- Taxes on Cannabis Products H-95.923

Resolution 213 – Telemedicine Services and Health Equity

- Addressing Equity in Telehealth H-480.937
- Coverage of and Payment for Telemedicine H-480.946

Resolution 214 – Advocacy and Action for a Sustainable Medical Care System

- Physician Payment Reform H-390.849
- Sequestration D-390.946

Resolution 218 – Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners

- Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950
- Physician Assistants and Nurse Practitioners H-160.947
- Physician Assistants H-35.989
- Models/Guidelines for Medical Health Care Teams H-160.906
- AMA Support for States in Their Development of Legislation to Support Physician-Led, Team Based Care D-35.982
- Practicing Medicine by Non-Physicians H-160.949

Resolution 219 – Repealing the Ban on Physician-Owned Hospitals
by the following policy:

- Hospital Consolidation H-215.960

Resolution 220 – Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations

- Importance of Clinical Research H-460.930
- Prevent Medicare Advantage Plans from Limiting Care D-285.959
- Medicare Advantage Policies H-330.878

Resolution 222 – Physician Ownership of Hospital Blocked by the ACA

- Hospital Consolidation H-215.960

Resolution 223 – Protecting Access to Gender Affirming Care

- Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927
- Medical Spectrum of Gender D-295.312
- Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population H-140.824
- Affirming the Medical Spectrum of Gender H-65.962
- Discriminatory Policies that Create Inequities in Health Care H-65.963

Resolution 224 – Advocacy Against Obesity-Related Bias by Insurance Providers

- Addressing Obesity D-440.954

Resolution 227 – Reimbursement for Postpartum Depression Prevention

- Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953
- Preventive Services H-425.997
- Value of Preventive Services H-460.894

Resolution 229 – Firearm Regulation for Persons Charged with or Convicted of a Violent Offense

- Violence as a Public Health Issue H-515.979
- Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

Resolution 231 – Equitable Interpreter Services and Fair Reimbursement

- Certified Translation and Interpreter Services D-385.957
- Physician Reimbursement for Interpreter Services D-385.946
- Interpreters in the Context of the Patient-Physician Relationship H-160.924
- Patient Interpreters H-385.928
- Interpreter Services and Payment Responsibilities H-385.917
- Appropriate Reimbursement for Language Interpretive Services D-160.992
- Use of Language Interpreters D-385.978
- Discrimination Against Physicians by Health Care Plans H-285.985
- Interpreters For Physician Visits D-90.999
- Availability and Payment for Medical Interpreters Services in Medical Practices H-385.929
- Support for Standardized Interpreter Training D-300.976

Resolution 232 – Supervised Injection Facilities (SIFs) Allowed by Federal Law

- Pilot Implementation of Supervised Injection Facilities H-95.925

Resolution 233 – Dobbs-EMTALA Medical Emergency

- Opposition to Criminalization of and Civil Liability for Pregnancy Loss as the Result of Medically Necessary Care D-160.911
- Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era D-5.998
- Preserving Access to Reproductive Health Services D-5.999

Resolution 234 – Medicare Physician Fee Schedule Updates and Grassroots Campaign

- Physician Payment Reform H-390.849
- Sequestration D-390.946

Resolution 238 – Eliminate Mandatory Medicare Budget Cuts

- Physician Payment Reform H-390.849
- Sequestration D-390.946

Resolution 242 – Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting Procedure

- Managed Care H-285.998

Resolution 243 – Replacing the Frye Standard for the Daubert Standard in Expert Witness Testimony

- 9.7.1 Medical Testimony

Resolution 244 – Recidivism

- Community-Based Treatment Centers H-160.963
- Increased Funding for Drug-Related Programs H-95.980
- Inhalant Abuse H-95.962

Resolution 245 – Biosimilar Interchangeable Terminology

- Biosimilar Interchangeability Pathway H-125.976

Resolution 246 – Modification of CMS Interpretation of Stark Law

- Access to In-Office Administered Drugs H-330.884

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Resolution 248 – Supervised Consumption Sites

- Pilot Implementation of Supervised Injection Facilities H-95.925

Resolution 249 – Restrictions on Social Media Promotion of Drugs

- Addressing Social Media and Social Networking Usage and its Impacts on Mental Health D-478.965
- Medical and Public Health Misinformation in the Age of Social Media D-440.915
- Prevention of Drug-Related Overdose D-95.987
- Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988

Resolution 250 – Medicare Budget Neutrality

- Physician Payment Reform H-390.849
- Sequestration D-390.946

Resolution 252 – Strengthening Patient Privacy

- Patient Privacy and Confidentiality H-315.983
- Supporting Improvements to Patient Data Privacy D-315.968
- Integration of Mobile Health Applications and Devices into Practice H-480.943

Resolution 253 – Appropriate Compensation for Non-Visit Care (Remote or Care of Coordination)

- Addressing Equity in Telehealth H-480.937
- Audio-Only Telehealth for Risk Adjusted Payment Models D-480.962

Resolution 254 – Eliminating the Party Statement Exception in Quality Assurance Proceedings

- Legal Protections for Peer Review H-375.962

Resolution 313 – Filtering International Medical Graduates During Residency or Fellowship Applications

- 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
- Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310-945

Resolution 315 – Prohibit Discriminatory ERAS® Filters In NRMP Match

- 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
- Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310-945

Resolution 317 – Supporting Childcare for Medical Residents

- Supporting Child Care for Health Care Professionals D-200.974

Resolution 425 – Examining Policing Through a Public Health Lens

- Improving the Accuracy of Death Certificates H-85.981
- Policing Reform D-65.987
- Policing Reform H-65.954

Resolution 426 – Accurate Abortion Reporting with Demographics by the Center for Disease Control

- Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted G-605.009

Resolution 431 - Qualified Immunity Reform

- Policing Reform D-65.987
- Policing Reform H-65.954

Resolution 510 – Comparative Effectiveness Research

- Comparative Effectiveness Research D-460.973
- Comparative Effectiveness Research H-460.909

Resolution 515 – Regulate Kratom and Ban Over-The-Counter Sales

- Kratom and its Growing Use Within the United States H-95.934
- Dietary Supplements and Herbal Remedies H-150.954
- Addressing Emerging Trends in Illicit Drug Use H-95.940

Resolution 516 – Fasting is Not Required for Lipid Analysis

- Prevention of Coronary Artery Disease H-425.990
- Medical Evaluations of Healthy Persons H-425.994

Resolution 522 – Approval Authority of the FDA

- Supporting Access to Mifepristone (Mifeprex) H-100.948
- FDA H-100.992
- Food and Drug Administration H-100.980

Resolution 523 – Reducing Youth Abuse of Dextromethorphan

- Harmful Drug Use in the United States - Strategies for Prevention H-95.978

Resolution 524 – Ensuring Access to Reproductive Health Services Medications

- Supporting Access to Mifepristone (Mifeprex) H-100.948
- FDA H-100.992
- Food and Drug Administration H-100.980

Resolution 701 – Reconsideration of the Birthday Rule

- Expanding Choice in the Private Sector H-165.881
- Individual Health Insurance H-165.920
- Health System Reform Legislation H-165.838

Resolution 702 – Providing Reduced Parking for Patients

- Non-Emergency Patient Transportation Systems H-130.954
- Voluntary Health Care Cost Containment H-155.998
- Health Promotion and Disease Prevention H-425.993
- Resident and Fellows' Bill of Rights H-310.912

Resolution 703 – Tribal Health Program Electronic Health Record Modernization

- Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987
- Maintenance Payments for Electronic Health Records D-478.975
- Improving Health Care of American Indians H-350.976
- Indian Health Service H-350.977
- Principles for Hospital Sponsored Electronic Health Records D-478.973

Resolution 705 – Aging and Dementia Friendly Health Systems

- Alzheimer's Disease H-25.991
- Physicians and Family Caregivers: Shared Responsibility H-210.980
- Health Care for Older Patients H-25.999
- A Guide for Best Health Practices for Seniors Living in Retirement Communities H-25.987
- Senior Care H-25.993

Resolution 711 – Doctors' Risk for Termination of Liability Coverage or Medical Privileges Consequent to Dobbs

- Preserving Access to Reproductive Health Services D-5.999
- Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era D-5.998

Resolution 713 – Redesigning the Medicare Hospice Benefit

- Hospice Care H-85.955
- Hospice Coverage and Underutilization H-85.966
- End-of-Life Care H-85.949
- Good Palliative Care H-70.915
- Concurrent Hospice and Curative Care H-85.951
- Support for the Quadruple Aim H-405.955
- Plan for Continued Progress Toward Health Equity H-180.944

Resolution 714 – Improving Hospice Program Integrity

- Fraud and Abuse Within the Medicare System H-175.981
- Health Care Fraud and Abuse Update H-175.984

Resolution 715 – Published Metrics for Hospitals and Hospital Systems

- Physician Satisfaction D-405.985
- Capturing Physician Sentiments of Hospital Quality D-215.988
- Due Diligence for Physicians and Practices Joining and ACO with Risk Based Models (Up Side and Down Side Risk) D-385.953
- Factors Causing Burnout H-405.948
- Physician Burnout D-405.972

Resolution 716 – Transparency and Accountability of Hospitals and Hospital Systems

- Hospital Medical Staff Relationships – Dispute Resolution H-225.979
- Affirmatively Protecting the Safety and Dignity of Physicians and Trainees as Workers D-515.977
- Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions H-65.951
- Factors Causing Burnout H-405.948

Resolution 717 – Improving Patient Access to Supplemental Oxygen Therapies

- Managed Care H-285.998

Resolution 718 – Insurance Coverage of FDA Approved Medications and Devices

- Drug Availability H-100.991
- Status Report on the Uninsured H-185.964

Resolution 722 – Expanding Protections of End-of-Life Care

- Hospice Care H-85.955
- Hospice Coverage and Underutilization H-85.966
- End-of-Life Care H-85.949
- Good Palliative Care H-70.915
- Concurrent Hospice and Curative Care H-85.951

Resolution 723 – Vertical Consolidation in Health Care – Markets or Monopolies

- Hospital Consolidation H-215.960
- Health System Consolidation D-215.984
- Health Care Entity Consolidation D-383.980

CLOSING REPORT**HOUSE ACTION: ADOPTED**

Mister Speaker, Members of the House of Delegates:

Your Committee on Rules and Credentials wishes to commend the Speaker, Doctor Scott, and the Vice Speaker, Doctor Egbert, for the outstanding manner in which they have assisted our deliberations by their fair and impartial conduct of the House of Delegates and to commend the members of the House for their cooperation in expediting the business before us.

Your Committee wishes at this time to offer the following Resolution:

Whereas, The Annual Meeting of the House of Delegates of the American Medical Association has been convened in Chicago, Illinois, the period of June 9-14; and

Whereas, This Annual Meeting of the House of Delegates has been most profitable and enjoyable from the viewpoint of policy deliberations and fellowship; and

Whereas, The City of Chicago has extended to the members attending this meeting the utmost hospitality and friendliness; therefore be it

RESOLVED, That expressions of deep appreciation be made to the AMA Board of Trustees for arranging this meeting, to the management of the Hyatt Regency Chicago, to the City of Chicago, and to the splendid men and women of our American Medical Association staff who participated in the planning and conduct of this Annual Meeting of the House of Delegates.

Mister Speaker, This concludes the Report of the Committee on Rules and Credentials, and we recommend its adoption.

APPROVAL OF MINUTES: The Proceedings of the 2022 Interim Meeting of the House of Delegates, held Nov. 12–15, 2022, were approved.

ADDRESS OF THE PRESIDENT: AMA President Jack Resneck Jr., MD, delivered the following address to the House of Delegates on Friday, June 9.

Dr. Speaker, Dr. Vice Speaker, Members of the Board, delegates, colleagues, and guests.

It's my honor to be with you this evening. I won't spend all of my final address to this House dwelling on the very real, very dangerous external attacks engulfing our profession. You got to hear from "angry Jack" in November, when I channeled my deep frustration with anti-science aggression, disinformation, payment cuts, and the many practice burdens driving burnout, not to mention the growing number of states and courts forcing themselves into the most intimate and difficult conversations patients and physicians share.

All of us here today are leaders in medicine, representing physicians back home. And so, we carry the burden of these hardships for them, which makes us all acutely aware of how daunting these challenges feel to our colleagues on the frontlines. I'm sure some of the headlines about burnout stop you in your tracks – they certainly keep me up at night. One in five physicians plans to leave their practice within two years, while one in three is reducing hours. Only 57 percent of doctors today would choose medicine again if they were just starting their careers. Consider that for a moment. This means that about two in five physicians go beyond mere daydreams of another career to wishing they had never chosen this path in the first place. This is a stunning indictment of the dysfunctional health care environment that is pushing record numbers of physicians to the brink.

In my inaugural address last year, and again at the Interim Meeting, I told the story of a Cleveland woman and casual runner who mistakenly ran the Cleveland marathon instead of the 10k she had signed up for. Georgene Johnson's determination to finish the race, despite her lack of preparation, makes it an endearing story, and a perfect metaphor for all of us who pursued this profession to heal others only to find ourselves confronting a reality that is unlike anything we imagined. While Georgine's story never failed to get a laugh, I've thought a lot about where the metaphor may have missed the mark. Lucky for Georgene, marathons have a defined end. You break the tape at the finish line, and you're done. There is no more running to do. But in these difficult times for medicine in America, our work in organized medicine has no finish line. New challenges keep appearing, and many existing ones seem to endure. We are knocked down, we dust ourselves off and get back up. We accumulate victories – some small, some large but we keep running. Don't bother looking for the rest areas between our races – I can assure you, you won't find them.

But as physicians and healers, we are already very accustomed to persevering. And we're darn good at it. We stick with patients suffering from chronic illnesses like diabetes or depression through setbacks and successes. We keep trying to convince that longtime smoker to quit, schedule yet another appointment to talk with a hesitant family about vaccinating their child, and show up for yet another trauma shift to face an endless stream of gun violence victims. We never turn our backs on our patients because that's NOT who we are. And we carry that same stubborn resolve and tenacity into our advocacy work.

That means fighting for long overdue fixes to a broken Medicare payment system, and obnoxious prior auth abuses, even when policymakers have neglected the problems for decades. That means defending against broad scope expansions that put patients at risk, even when it requires gearing up again and again, in state after state. That means confronting medical disinformation in the news and on social media, even when its growth feels overwhelming. And yes, it means battling in state legislatures and courthouses for the very soul of our nation and our profession – to protect patients from those outside influences wanting to dictate the terms of their care. Telling them what medical treatments their physicians can provide ...what FDA-approved medicines we can prescribe....even what words we can use. This is what happens when politicians force their way into our exam rooms. This isn't about science. Interfering with the sacred patient-doctor relationship is about CONTROL.

I know it can feel like victory is out of reach -- that we're running out of breath and running out of time. But we all share a commitment to stay in this race. We play the long game, and we're in it to win. So perhaps instead of the marathon analogy, it's better to think about our collective efforts like the Olympic torch relay. Don't worry, I'm not heading for the obvious metaphor of a relay race, with one leader handing over the torch to the next. I'm talking about the deeper symbolism of the unity among torch carriers, thousands at each Olympics protecting something far bigger than any one individual, or any one leg of the course. In our own professional tradition, the work to preserve our core values, and the health of our patients, is itself. The enduring common cause that binds us. The torch relay and the lighting of the Olympic flame are indelible parts of the games. And in that sacred tradition, as in ours, there are no shortcuts. There are no substitutes for the actual flame, which is carried forward to the games by any means necessary – by running, jogging, or swimming; by horse, boat, train, or plane and once underwater past the Great Barrier Reef. The torch has even gone to space. The passing of the torch, and the tradition it embodies, has survived every conceivable challenge. It has been rerouted by war. Its symbolism has been coopted for propaganda. It's been briefly extinguished by wind, by rain, and even by protestors. But one way or another, the tradition lives on.

I like this metaphor for our work together in organized medicine because it's not solely about passing a baton; it's about giving of yourself to a larger mission. It's about persevering with unyielding resolve. The challenges that threaten the torch may change, but the larger mission does not. The AMA doesn't win every battle. But we are more resolute in our work because of the threats to our profession and our patients. Even when there are temporary setbacks, our common cause is to speak out for, and to advance our flame, our ethical values, and our common purpose – that is what keeps us going. All of us here tonight...we recognize the extraordinary privilege to be part of something worth preserving and worth renewing for the next generation. That's the power in what we do.

I want to share some thoughts about where we are on this leg of the race, and some positive signs of hope. No, I can't sugarcoat the very real threats. I'm still appalled by the Medicare cuts. What on earth was Congress thinking? Practices are on the brink. Our workforce is at risk. Access to care stands in the balance. We absolutely must tie future Medicare payments to inflation, and we're readying a major national campaign to finally achieve Congressional action. And shame on political leaders, fueling fear and sowing division by making enemies of public health officials, of transgender adolescents, of physicians doing anti-racism work, and of women making personal decisions about their

pregnancies. I'm also deeply disappointed by our nation's lack of progress to address the public health crisis of gun violence. Preventable and needless homicides and suicides continue, and the political inaction is atrocious.

But over the past year, I've had the privilege of appearing in public on your behalf more times than I can count. And that has afforded me many opportunities to absorb just where our profession, and the public, stand in this divisive time. And I want to tell you something I've learned. There are more people who agree with us than those who do not. Are there different ideologies around solving the challenges we face? Yes. Are there different strategies for achieving our goals? Of course. Do people get their news from entirely different channels with little overlap? Sadly, yes. But...the truth is, most physicians and our patients are proud to see the AMA fighting for its policies and values. I know what you are thinking, "Jack, have you been on Twitter lately?" Oh yes...I have. But I've also witnessed some of the most inspiring work in the country by colleagues and allies, and received words of encouragement that have brought me to tears on difficult days.

You wouldn't know it from social media, but after some unfortunate detours, most patients are turning back to their trusted physicians for our insights and expertise about science and medicine. You wouldn't know it from the rhetoric, but once we demonstrate health equity in action. I've seen widespread support for the work. I loved traveling to Mississippi and witnessing their progress from startling COVID inequities to achieving one of the nation's top vaccination rates among Black residents. You wouldn't know it from the appalling lack of legislative action, but solid majorities of Americans believe in commonsense gun reforms in line with our AMA recommendations. You wouldn't know it from 20 state legislatures racing to criminalize abortion and rob women of access to reproductive health care, but most people in this country support our policies and the fundamental rights of patients to make their own decisions about their health. You wouldn't know it from health insurers still bullying us with prior auth delays and denying care, but policymakers from both parties are onto these schemes, the momentum has shifted, and they're not going to allow this nonsense anymore. You may not realize it, based on the climate of anti-science aggression, but medical school applications are at an all-time high, led by large increases among historically minoritized students. Future physicians are not dissuaded by these challenges. They are eager to join our fight.

In our country, and in our profession, we don't agree on everything, but we agree on enough things to pursue the shared things that we care about. Together. And let us not forget that those pursuits have generated some big and small wins tied to the AMA Recovery Plan for America's Physicians. I know what you're thinking. Recovery Plan? What's that? I've never heard of it before. I know, I know... your hundredth exposure to the video loop on our buses at Interim may have been overkill. But for the public and physicians back home, they need to know about our relentless work fighting to restore the sustainability of our profession. In that race, the Recovery Plan is our roadmap and our message.

As I said in November, we need to fix what's broken in health care, and it's NOT the doctor. Duct-taping the widening cracks of a dilapidated Medicare payment system isn't sustainable. The patches aren't holding. Linking physician payment to inflation is an absolute top priority, an existential must to keep practices afloat, and pillar #1 of our plan. An important step on that path was the recent introduction of a bipartisan bill to finally align the Medicare fee schedule with MEI.

On other pillars, our Congressional advocacy played a key role in legislation to extend Medicare telehealth coverage. In partnership with states and specialties, our advocacy has helped protect patients from outrageous and broad scope expansions more than 50 times so far this year. State after state is making progress to constrain prior authorization, and CMS issued rules to do the same in Medicare Advantage plans. And we have been instrumental in helping create confidential wellness programs for physicians and removing outdated questions from past impairment from licensing and credentialing forms. And the AMA is achieving success on the breadth of policies from this House beyond our Recovery Plan as well.

The FDA is making Naloxone available over the counter ... and may be on the verge of doing the same for an over-the-counter oral contraceptive. The FDA has also finally removed many outdated restrictions on blood donations from men who have sex with men. Medicaid work requirements that conflict with AMA policy were kept out of the debt ceiling bill. We've helped shift the national conversation about protecting patient data and making sure digital health and AI tools are proven BEFORE being deployed. We've broadened and intensified our work to embed equity and racial justice, and to push upstream to affect structural and social drivers of health inequities. And our litigation center has been very, very busy. We've joined others in suing Cigna for shortchanging doctors and patients. We forced the federal government to take steps towards banning menthol cigarettes. The Wisconsin Supreme Court agreed with us that patients and judges can't force physicians to administer substandard care. Courts have invalidated parts of No

Surprises Act rules that plainly ignored Congressional intent and put a thumb on the scale to favor insurance companies... thank you Texas Medical Association and AMA! The 5th Circuit Court is staying- for now – an egregious ruling that would have stripped patients of the right to access preventive care service with no out-of-pocket costs, a key piece of the Affordable Care Act. The U.S. Supreme Court is delaying attempts by a single district judge with no scientific or medical training to take mifepristone off the market nationally and upend our entire FDA drug regulatory process. We're briefing in more courts than I can count to turn back criminalization of medical care. And we're not done yet. Not even close.

In my inaugural address, I admitted to being a pragmatic optimist who believes in relentlessly showing up and using levers of power to help create a more just and equitable system. I remain undeterred – even though the challenges we face today are daunting. The burnout and the moral injury are real. I've felt it myself. I hear this concern in the voices of medical students, residents, and even young physicians when they ask me, "Am I going to be okay?" "Have I made the right career choice?" The first message I share: Yes, I'm confident that you have made the right choice. You are joining an extraordinary profession, and we are lucky to have you. Don't ever lose your passion for humanity and healing.

And the second message I give them ... there is no time to waste, so let's get to work. "You want a more equitable future for patients?" Demand it. "You want a future where our health care system and new technologies support physicians rather than burdening us?" Create it. "You want patients making their own decisions about their health? Fight for it. You are entering the profession for all the right reasons and to fix all the right problems ... and there will be more.

We have enormous privilege to do this work. We share a love for what we do – to help...to cure...to listen...to solve...to heal...to lead. And we have a responsibility to our patients AND to the health of this nation. WE are the keepers of an important tradition. A flame that must NOT be extinguished. Our profession is counting on us to get this right. Our patients are depending on us to continue this fight. We will not let them down.

Thank you.

REPORT OF THE EXECUTIVE VICE PRESIDENT: James L. Madara, MD, executive vice president of the Association, delivered the following address to the House of Delegates on Friday, June 19.

Dr. Speaker, members of the board, delegates, and guests.

The Internal Revenue Service classifies us as a membership organization - now, how's that for an exciting opening line!

AMA membership grew 11 of the last 12 years and our market share increased as well. But we're not solely defined by that. The AMA engages physicians in multiple ways...more like an equation. The components of that AMA equation include not only membership, but the resources we create, our business products, our research and education activities, our state and federal advocacy, legal actions to improve the health of our nation, and finally, the work of this House of Delegates.

The House is a vital component of that AMA equation, with policy being your product. The vast majority of physicians belong to one or more of the societies of this House. I belong to three. Thus, by definition, most physicians are represented here in this room. That connection conveys something specific to many, particularly those in Washington DC. It conveys that AMA policies provide the clearest surrogate of the net of physician voice.

Having said that, there's another fact to wrestle with. Although physicians love democratic debate, we also highly value our independence of thought. We are protective of our individual agency. Can we all agree on that: the duality of attractiveness of democratic debate coupled with fierce independence? What results from that duality? Just because a policy is adopted by a 60-40 margin doesn't mean that those 40 percent voting against it are now perfectly – or even generally – aligned with that policy. I suspect many of those voting against an adopted policy continue to think that policy is flawed. Personal agency is valued even when contrarian to the majority.

I experienced that tension on entering the AMA as CEO, 12 years ago. When asked about a health issue, I had to recognize that the answer to such questions was simply: "AMA policy states X and Y." That answer is specifically responsive to the question of "what do physicians, broadly considered, think about this topic?" This habit of deference to our policy also aligns with what sociologists refer to as "the wisdom of the crowd." Group decisions do arc toward wisdom.

That tension between agency and democracy is amplified in our current environment, an environment of tension around social conflicts of the day. A few weeks ago, I learned of a physician who had been a member of the AMA for 43 years and now he was cancelling his membership. Curious about why, I gave him a call. We had a warm chat; at the end he offered to treat me to lunch. He enjoyed our products, the viewpoints in JAMA, and how we effectively advocated on his behalf of him and his patients. We discussed how the AMA fights for the sanctity, privacy, and freedom of the patient-physician relationship. He appreciated all of that, but still thought he would cancel his membership. So, since he believed he received value from his membership, why was he still inclined to end it after 40 years? It boiled down to this: Regardless of the various benefits and alignments, his decision hung on a strong objection to one, I repeat, ONE, specific policy. To me this seemed a bit unreasonable – unreasonable in the sense of his agency being so narrowly vested in a single issue. But, who knows, I suppose I might get cantankerous in my later years as well.

The reason I share this physician's story is because, increasingly, our national environment tilts toward defining our individual stance, by where we differ instead of where we agree. That's particularly true around issues involving race, gender, reproductive rights, religious beliefs, all which can lean toward absolutist disagreements given that focus on differences rather than commonalities. There're no shortage of hot-button issues taken on by this House. You debate and discuss firearm violence, reproductive health, vaccine science, gender-affirming care, the consequences of structural racism, and other topics. The result of these debates are House policies some of which lead to the creation of new programs and initiatives such as the AMA Center for Health Equity, important work that now extends to the newly launched Truth, Reconciliation, Healing and Transformation Task Force which was requested by this House. This is a Task Force composed of nationally recognized leaders, which will advise the AMA Board. You can learn more about this Task Force at Sunday's Health Equity Open Forum.

In arriving at policies on challenging topics, one might take the approach of technology forecaster Paul Saffo. And that is to formulate "strong opinions, weakly held." "Strong opinions weakly held" at first sounds an oxymoron, but

consider the intent. A strong opinion is such because it's based on the best available evidence. But the strong opinion is weakly held in the sense that should new evidence come along that supersedes that of the past, one should be willing to modify opinion. That's to say, we should be willing to adjust our opinion to best fit current evidence rather than holding tightly to views based on legacy environments. If you agree that our macro-environment nudges toward conflict and that conflict is heightened if strong legacy opinions are allowed to trump new evidence, then one tonic for this dilemma might be a willingness to forgo narrow definitions of personal agency. To consider our agency as a balance instead of a narrow set of non-negotiable must-haves...to be satisfied with a 70-30 personal portfolio of policy outcomes rather than either a thirst for 100-0 or push all one's agency cards to the table based on a single policy or two. To support the wisdom of the crowd as a means of moving forward the needs of patients and physicians – and doing so respecting the majority. If just a few on the 40 percent side of any policy vote would do that, the effect could amplify cooperation. A study in the Proceedings of the National Academy shows exactly that cooperative behavior by one person tends to cascade through social networks. Unfortunately, uncooperative behaviors also cascade.

APCO Worldwide, a strategic communications firm, releases an annual branding study of 50 impactful associations representing all industries, and the AMA represents physicians within the six-member health care group. The other five in this group include major associations representing hospitals, payors, biotech, insurers, or the pharmaceutical industry. The AMA routinely does well in comparison to these other associations, and one strong key performance indicator is "unified voice of the profession." We can be stronger and yet more effective if we are willing – even if only to a degree – to accede to the wisdom of the crowd, that is, to nudge ourselves to embrace, or at least not actively resist, the resulting votes of this House; doing so as a "tip of the cap" to the overall wisdom of physicians.

Typically, in my comments to the House, I highlight advances in our strategic framework. My intent here was different. It was to focus on culture, particularly given our current national discourse that can feel like a pie-in-the-face is a reasonable form of debate. It is also likely that the pandemic, particularly in the early going, concentrated attention and helped unify our voice. Let's not take such progress toward unity and throw it out with the pandemic bathwater. We would do well by gently sculpting our agency to allow greater cooperation ... acceding to the wisdom of the crowd when it comes to policy – doing so to make this powerful convening association even more impactful as we "promote the art and science of medicine and the betterment of public health."

And that, my friends, is more thought-provoking than any IRS classification.

Thank you and have a great meeting.

REMARKS OF THE CHAIR OF THE AMPAC BOARD: The following remarks were presented to the House of Delegates on Friday, June 9 by Brooke Buckley, MD, Chair of the AMPAC board.

Dr. Egbert, leaders of the House, delegates, I am so humbled to be in front of you today addressing you as the first female Chair of AMPAC in our nearly 60-year history. But, most importantly, I want to say thank you to the doctors and the Alliance members who have joined AMPAC, both at a regular membership level, but specifically those who year over year have committed to the Capital Club membership. We thank you. We appreciate your support, and I'd like to tell you a little bit more about why your support is so vital to the crucial time that we are in in medicine now.

AMPAC, as you know, is the nonpartisan political action committee for the AMA. AMPAC donations facilitate relationships with lawmakers. These relationships afford us the opportunity to lobby for our AMA policy positions. Without strong lobbying, we lose our audience with politicians. In this complex political environment, I have so often heard, "It's too messy; too distasteful. I cannot morally and ethically participate with AMPAC." I know that there are many of us in this room that feel at least a little bit of that; if have not acted on it, certainly can resonate a little bit with those feelings. However, if we do not donate to AMPAC, we do not have dollars to help support our lobbying efforts. As Rob Jordan, our Director of Political and Legislative Grassroots, shared: "I cannot imagine a better way to give the other side an easy win, other than leaving the battlefield." For a moment, if you will, imagine a world where the AMA does not hold political influence. How do we turn the hard work of this House into a reality? How do we take these policy efforts and make them real? Imagine spending all these days at the House away from your family, from your practice, to design policies that never have a chance to become more than words on a page. Imagine physicians losing their voice.

AMPAC needs your dollars to open doors. The American political arena is messy, and not all who can help us support key initiatives are typical friends of medicine. But every relationship facilitated by AMPAC dollars is carefully managed to enhance the AMA mission guided by the policies that we are here crafting this week and every annual and interim meeting. The AMA House of Delegates makes policies; politicians make laws. Our policy becomes law only when a politician votes for a bill consistent with our policy, and laws create the change that we desire.

Politicians are imperfect humans, like us. AMPAC gives us an audience with these humans, and AMPAC facilitates our ability to speak our case. Our lobbyists are brilliant at what they do. We need to support their work on behalf of our AMA. Please give to AMPAC.

Thank you again to our major donors, our Capital Club members. Please come join us for our Capital Club luncheon on Tuesday. Please visit our booth and donate to AMPAC. And if you aren't convinced, please stay curious. Ask more questions, because AMPAC needs you, the AMA needs you, and, most importantly, our patients need our policies to become law to drive the structural change that we need for a better health in America.

Thank you.

RETIRING AMA OFFICERS, DELEGATES AND MEDICAL EXECUTIVES**Air Force**

Paul Friedrichs, MD

Oklahoma

Jack J. Beller, MD

Wisconsin

Charles Rainey, MD

American College of Emergency Physicians

Nancy J. Auer, MD

American Society of Transplant Surgeons

Thomas G. Peters, MD

College of American Pathologists

William V. Harrer, MD

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Reference Committee on Amendments to Constitution and Bylaws

Brandi Ring, MD, MBA, American College of Obstetricians and Gynecologists, Chair
 Stephen Richards, DO, American Academy of Family Physicians
 William Sternfeld, MD, Ohio
 Mark Casanova, MD, Texas*
 M. Eugene Sherman, MD, American College of Cardiology
 Jade A. Anderson, MD, American College of Radiology*
 Kenath Shamir, MD, Massachusetts*

Reference Committee A (Medical service)

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Reference Committee E (Science and technology)

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 Daniel Kerekes, MD, MHS, Connecticut
 Alan Klitzke, MD, American College of Nuclear Medicine
 Reilly Bealer, MD, Washington*
 Raymond Lorenzoni, MD, Connecticut*
 Jennifer R. Rushton, MD, Texas*
 Raymond Tsai, MD, California*

Reference Committee F (AMA finance, governance)

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 Robyn F. Chatman, MD, MPH, Ohio
 Rebecca L. Johnson, MD, Florida
 Shilpen A. Patel, MD, American Society for Radiation Oncology
 William C. Reha, MD, MBA, American Association of Clinical Urologists, Inc.
 Michael B. Simon, MD, MBA, American Society of Anesthesiologists

Reference Committee G (Medical practice)

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 Theodore Jones, MD, Michigan
 Don Lee, MD, Wisconsin
 Thomas G. Peters, MD, American Society of Transplant Surgeons
 R. Brent Wright, MD, MMM, Kentucky*
 Sherif Zaafran, MD, Texas*

Committee on Rules and Credentials

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 Robert H. Emmick, Jr, MD, Texas*
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 Carlos A. Latorre, MD, MS, Mississippi
 Christopher P. Libby, MD, MPH, American College of Emergency Physicians
 Christopher McAdams, MD, Georgia*

Chief Teller

Jordan M. Warchol, MD, MPH, Nebraska

Assistant Tellers

Charlie Adams, Missouri*
 Bryan G. Johnson, MD, Texas*
 Vikram B. Patel, MD, Illinois*

* Alternate delegate

INAUGURAL ADDRESS: Jesse M. Ehrenfeld, MD, MPH, was inaugurated as the 178th President of the American Medical Association on Tuesday, June 13. Following is his inaugural address.

A More Inclusive and Equitable Future for Medicine

Thank you, Dr. Fryhofer. Thank you to all of these remarkable physician leaders seated behind me.

And thank you to all of you for being here tonight. What an incredible honor to address you for the first time as your AMA president.

With us tonight are so many people from all periods of my life. Childhood friends from Delaware, classmates from college and medical school. My longstanding and primary research mentor who opened the door for me to an academic career, colleagues from Vanderbilt, the Medical College of Wisconsin, and several shipmates that I was privileged to serve alongside in the Navy. All of you are so incredibly special to me; thank you for being part of this night.

I want to recognize two people in particular, seated here on stage: Army Commanding General Mary Krueger, a courageous advocate for the inclusion of LGBTQ individuals in the military and beyond throughout her storied career as a family physician. Thank you, Mary for always standing up when it matters.

Also beside me is Dr. John Raymond, president and CEO of the Medical College of Wisconsin, who is a remarkable physician leader and an even more remarkable man. Your kindness and compassion inspire me every day in all my work. Thank you, John.

And of course, my immediate family in the front row: my father David Ehrenfeld, a retired family dentist who practiced for 45 years and never turned away a patient who called with an after-hours emergency. My mom Katharine Nicodemus, a psychologist with a still incredibly busy solo private practice. You always showed us the importance of education, even though you prioritized mine over yours, resulting in our simultaneous graduation from high school and graduate school the same year. My brother Josh, who was always there for me in a pinch, even if meant driving a car halfway across the country in the middle of the night.

My two beautiful boys, Ethan and Asher, 4 years old and 4 months old, respectively – you have brought indescribable joy into our life and I love being challenged by you and watching you grow each day.

And of course, my husband Judd Taback: a public service attorney who has dedicated his entire professional career to service. You have been my partner in crime for nearly 12 years now, married for half of them. You have given up so much to support my dreams, including every birthday since we met to come to the AMA annual meeting. You have been there for every celebration, every sorrow, always with the right words and the right embrace to support me and our family in any and every circumstance. You inspire me through your strength and your love, each and every day. I can't imagine this moment without you and Asher and Ethan.

Now, Ethan just turned 4. His road to pre-kindergarten hasn't been an easy one. He was born 10 weeks early and weighed just 2 lbs 7 oz. For the physicians in the room – ok, most of us – you know the serious complications that can arise when a child is born that early and that underweight. Ethan spent 49 days in the neonatal ICU at Illinois Masonic Hospital, just a few miles from here. While in the ICU, Ethan required a lot of care, a lot of medicine, and a lot of love to keep him alive. Judd and I will be eternally grateful for the physicians and nurses, and the medical innovations that saved his life. As new parents – seeing our child struggle was unimaginable. In those kinds of moments, you want to do everything possible, and give anything you can, to help your child's recovery.

When he was just a few weeks old, Ethan needed a blood transfusion. And as an anesthesiologist, I have given thousands of units of blood to hundreds of patients. But at this moment, watching my son cling to life, I was struck by the painful reality that, even though I was a physician and now, a father ... neither I, nor my husband, could donate blood – simply because we are gay. Discriminatory policies – policies rooted in stigma, not science – barred us from doing the most humane of acts, donating our blood. Thankfully, Ethan got the blood he needed. But that feeling of helplessness lingered with me for some time. I tell this story because I want people to understand what we mean when we talk about inequities and injustices in medicine.

This is just one of many experiences my husband and I have had with health inequities, and I know that too many of my colleagues and too many of the patients we care for also suffer from discrimination and discrimination in health care on a daily basis. It's the reason why Black women in the U.S. are at least three times as likely as white women to die during pregnancy. Why Black men are 50 percent more likely to die following elective surgery. It's why LGBTQ teens and young adults suffer higher rates of mental health challenges, both diagnosed and, far too often, undiagnosed. In Milwaukee, where I work and live, the infant mortality rate for white families is 3 per 1,000 births. For Black families, it's 18 per 1,000 births. So many injustices in health care remain – and are the focus of our AMA's advocacy on health equity and much of my personal work leading the Advancing a Healthier Wisconsin Endowment.

Just recently, the FDA, thanks in large part to a decade of advocacy by our AMA and others, rescinded some of these discriminatory practices, making it possible for my husband and I to give someone else's child a much-needed blood transfusion. This kind of advocacy is why I am so proud to lead our AMA at this moment. The AMA has made tremendous strides in recent years to recognize past wrongs, to take a stand against discriminatory practices in medicine, to stand on the side of justice and equity, and to partner with allies who are committed to advancing the rights of all patients to receive equitable care.

Today there is an unconscionable effort to interfere in medicine. An assault on patient and physician autonomy. Legislative over-reach. Attacks on maternal health ... on LGBTQ patients. There are also relentless efforts to redefine how medical care is practiced by expanding scope of practice for nonphysicians, creating more inefficiencies in the system, further siloing care, and putting patients at greater risk. And I will tell you these misguided efforts negatively impact patients in historically marginalized communities. The aspiration shouldn't be to provide lesser quality care to more people, it should be to provide high quality care for all people. All communities – including our nation's veterans and those from Native American and other historically marginalized communities – deserve access to a physician-led care team. As far as we have come, we have even further to go. And as I stand here tonight, I can't help but to be awed by the willingness of our AMA to make difficult and necessary change.

I have a vivid memory of walking for the first time into the AMA House of Delegates meeting here in Chicago in 2001 when I was a medical student. I had just finished my first year of medical school at the University of Chicago and the possibilities ahead of should have seemed limitless. But as I stood near the back of the room, I was struck by two competing feelings. I was in awe of the open and deliberative process. Here were physicians from all over the country, and from every specialty, debating health policy in minute detail. Here were medical experts establishing the policies, guidelines, and directives I would one day follow.

But another feeling settled in as well. I had an unshakable feeling of insecurity, knowing that as a gay man in medicine I was an outsider who might never be accepted for who I was, limiting my choices. The policy debates I heard were jarring to me. To hear the arguments against inclusivity. To hear arguments that flew in the face of science because of homophobia and ignorance. I knew who I was, but I wasn't sure there would ever be a place for me in our AMA. You have to remember that in 2001, there were no federal hate crime protections for LGBTQ people. Same-sex marriage was not legal in any state. Don't Ask Don't Tell was still the law of the land – and it would remain so when I was commissioned as an officer in the Navy some years later. In 1998, a young college student named Matthew Shepard was brutally murdered in Wyoming because of his sexual orientation. Matthew and I were the same age. I had only recently told my closest friends in college that I was gay. And for me, as for many of us in this community, Matthew's murder was as shocking as it was predictable. It was a salient reminder of the very real threats that people like me face every day when we live as our authentic selves. Here at our AMA, there was not yet an LGBTQ Advisory Committee or Section. There were no policy discussions that focused on the health needs of my community. There were few openly gay physicians to look up to. Our AMA had only amended its policies eight years earlier to specifically prevent discrimination on the basis of sexual orientation – and had only outright opposed the practice of conversion therapy, one year before I joined the organization. And so, as a medical student – standing in that room and watching the deliberative process of the House of Delegates unfold – I had well founded fears about my place in society, never mind the profession of medicine.

A few years later, I became active in my state medical society during my residency in Boston and I helped to write and pass a resolution to form an LGBTQ committee to elevate the concerns of our community, not only as patients but as physicians and health care professionals. It was an effort that clearly did not sit well with everyone. I was pulled aside by a colleague and told that while creating an LGBTQ committee was all fine and good, continuing on

this path would bring a swift end to my career in organized medicine. I realized at that moment that my choices were to continue to hide who I am, or to help organized medicine evolve into a place that welcomed people like me. Standing on this stage tonight and accepting the honor of the AMA presidency is proof that our organization can evolve. This is why visibility matters. And this why, when you have a platform like this one, you have a responsibility to use it for the greater good ... and to try and lift up those who haven't yet found their voice.

Everyone in this room tonight knows that the profession of medicine is at a crossroads. On one hand we're witness to incredible new technologies and breakthrough scientific discoveries. Remarkable treatments. Amazing new medicines that make it easier to diagnose and cure common diseases and prolong life. And we're only just beginning to see the promise of A.I. – which has the potential to transform medicine. At the same time life expectancy in the U.S. is lower than it was when I was in residency. Maternal mortality is surging – more than doubling at the rate of other well-resourced countries. And we continue to face daily shortages of critical, life-saving medications. COVID-19 may not be the threat it once was, but we still face the twin epidemics of substance use disorders and deaths from firearm violence. And we face an ever-worsening mental health crisis in our nation, which has taken a disproportionately high toll on physicians. A dear medical school classmate of mine, who went into emergency medicine, worked tirelessly on the frontlines throughout COVID, struggled. I knew he struggled. But I didn't know how to help him. And he didn't know how to ask for help. And two years ago, I lost that friend to suicide. He was an energetic and loving soul, and I am haunted by his loss. He is yet one example of why I know our AMA must continue to advocate for the mental health needs of all physicians and of our patients.

Our profession – and our society – can do better. We must do better.

This is why both physicians and the public look to the AMA for leadership ... for guidance ... for reassurance ... and for help making sense of our complex world. At a time when so many aspects of society have become dangerously polarized, we have seen the proliferation of medical disinformation, junk science, the criminalization of medical care, and a growing distrust in medical institutions and experts. Our AMA has a duty to call out politically appointed judges who would upend 80 years of FDA precedent and threaten access to critical drugs long proven to be safe and effective. We have a duty to push back against legislative interference in the practice of medicine that is leading to the criminalization of care. We have a duty to fight for the recovery of America's physicians in the aftermath of the pandemic, pushing to fix our broken Medicare payment system, reform prior authorization, and end the stigma around physician burnout. We have a duty to make sure that the human connection that is so essential in medicine remains at the center of our increasingly digitized world. When I am sick, I want to know there is someone helping me who actually cares about me. Someone who understands my struggle, and my pain, and who brings with them the human emotions that are at the center of the patient-physician relationship. We have a duty to push for change to address the crisis of firearm violence. Every physician who has cared for an innocent victim of violence, whether from a school shooting, the Boston marathon bombing, the siege on Tree of Life Synagogue, the Pulse Nightclub massacre any of the other countless and completely senseless acts of violence that our country has endured can tell you of the heartbreak and the moral injury they suffered while trying to save as many lives as possible. We have to think about how we can engage in this divisive environment if we are to be successful in pushing for policy changes, advocating for what we believe in, and working to make a difference for our patients and our colleagues. And as president, I pledge to do all that I can to ensure that your voices – and your priorities – are heard.

Too often, it seems like many have forgotten the rules Ethan is learning in pre-kindergarten about sharing, being kind, and accepting others. I often think about the loss of trust and respect for one another that we see play out at every level of society. I hear from parents in my son's class about how they come from different backgrounds, different jobs, and different parts of town. There is a richness in the diversity in his class and in watching how these children interact. How the kids engage with one another oblivious to bias, to stereotypes, or to the fractures that have often been ingrained in their parents. So how do we break this cycle? What can we do, as physicians, to rise above division and bridge divides?

We use our voice. We speak up. We advocate. We call attention to injustice. We don't back down from the good fight. That's why I am so proud of the courage our AMA has shown by standing up for science. Standing up for ethics at a time of increasing aggression and hostility. I am proud to be at the helm of our organization as we continue to champion health equity and racial justice despite vocal – and powerful – opposition. It is easy to be discouraged by the enormity of the task at hand, but as I begin my term as president, I choose to embrace optimism. I choose optimism because I've seen how physicians have stepped up to counter disinformation, to shine a light on

the unacceptable toll of mental illness and violence, to address health disparities, and to get all patients access to the care that they need and deserve. I choose optimism because I work with young physicians and aspiring physicians who are driven by a bottomless sense of curiosity and a commitment to making a difference. The next generation's passion for medicine gives me hope for the future. I choose optimism because I have seen the impact of our AMA – and our capacity to speak out, adapt, fight injustices, and support physicians and patients in every corner of the country. I choose optimism because I believe there is still joy to be found in medicine, a reason nearly everyone in this room has dedicated our professional lives to helping, and healing, others. I choose optimism because even though I once stood in the back of this very room afraid of being rejected for who I was ... I now stand before you as the first openly gay president of our AMA, proudly representing everyone in this room, including everyone who has ever, or will ever, feel like an outsider.

While our AMA may not have the power to change every part of society that rejects people who are seen as different, we do have the ability and obligation to ensure health care is always a safe space. We can work to make sure all our patients are seen, heard, and accepted as they are. For too long medicine has been an unsafe place and an unwelcoming environment for far too many people. Although the work is difficult, slow, and imperfect, our AMA continues to strive to change medicine for the better, and to make the exam room a safe place for everyone who seeks our help. This is our charge as physicians. And this is the charge of our AMA.

Physicians across the country continue to shoulder the weight of enormous challenges. Yet despite these immense pressures – we physicians continue on. We do the work. We provide compassionate care. We make a difference. We change lives.

Twenty-two years ago at my first AMA meeting, I could never have predicted what medicine looks like today – both its challenges and its potential to lift up society. The challenge that lies before me and before all of us tonight is to collectively imagine what it should look like twenty-two years from today. Let us move forward with confidence and purpose. Let us speak with conviction. Let us hold firm to science and the ethics of our profession. Let us serve with honor, courage and commitment. And let us always fight for a more inclusive, and more equitable, tomorrow.

Thank you.