REPORTS OF THE BOARD OF TRUSTEES

The following reports were presented by Willie Underwood, III, MD, MSc, MPH, Chair:

1. ANNUAL REPORT

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: FILED

The Consolidated Financial Statements for the years ended December 31, 2023 and 2022 and the Independent Auditor's report have been included in the 2023 Annual Report. This is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.

2. NEW SPECIALTY ORGANIZATIONS REPRESENTATION IN THE HOUSE OF DELEGATES

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

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

The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the applications of the Academy of Consultation-Liaison Psychiatry, American College of Lifestyle Medicine, American Venous Forum, Association of Academic Physiatrists, and Society for Pediatric Dermatology for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

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

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

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

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

Review of the materials and discussion during the SSS meeting at the November 2023 Interim Meeting indicated that the Academy of Consultation-Liaison Psychiatry, American College of Lifestyle Medicine, American Venous Forum, Association of Academic Physiatrists, and Society for Pediatric Dermatology meet the criteria for representation in the HOD.

RECOMMENDATION

Therefore, the Board of Trustees recommend that the Academy of Consultation-Liaison Psychiatry, American College of Lifestyle Medicine, American Venous Forum, Association of Academic Physiatrists, and Society for Pediatric Dermatology be granted representation in the AMA House of Delegates and that the remainder of the report be filed.

APPENDIX

Exhibit A - Guidelines for Representation in & Admission to the House of Delegates: National Medical Specialty Societies

1) The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.

2) The organization must (a) represent a field of medicine that has recognized scientific validity; and (b) not have board certification as its primary focus, and (c) not require membership in the specialty organization as a requisite for board certification.

3) The organization must meet one of the following criteria:

   - 1,000 or more AMA members;
   - At least 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   - Have been represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.

4) The organization must be established and stable; therefore, it must have been in existence for at least 5 years prior to submitting its application.

5) Physicians should comprise the majority of the voting membership of the organization.

6) The organization must have a voluntary membership and must report as members only those who are current in payment of applicable dues are eligible to participate on committees and the governing body.

7) The organization must be active within its field of medicine and hold at least one meeting of its members per year.

8) The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.

9) The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.

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

Responsibilities of National Medical Specialty Organizations

1. To cooperate with the AMA in increasing its AMA membership.

2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.

3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.

4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting.

5. To provide information and data to the AMA when requested.

Exhibit B - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
Academy of Consultation-Liaison Psychiatry	378 of 1,471 (26%)
American College of Lifestyle Medicine	974 of 3,937 (25%)
American Venous Forum	115 of 439 (26%)
Association of Academic Physiatrists	162 of 779 (21%)
Society for Pediatric Dermatology	154 of 564 (27%)

3. 2023 GRANTS AND DONATIONS

Informational report; no reference committee hearing.

HOD ACTION: FILED

This informational financial report details all grants or donations received by the American Medical Association during 2023.

American Medical Association
Grants & Donations Received by the AMA
For the Year Ended December 31, 2023
Amounts in thousands

Funding Institution	Project	Amount Received
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Building Healthcare Provider Capacity to Screen, Test, and Refer Disparate Populations with Prediabetes	$ 44
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Improving Minority Physician Capacity to Address COVID-19 Disparities	257
Centers for Disease Control and Prevention	Improving Health Outcomes through Partnerships with Physicians to Prevent and Control Emerging and Re-Emerging Infectious Disease Threats	1,545
Centers for Disease Control and Prevention	National Healthcare Workforce Infection Prevention and Control Training Initiative Healthcare Facilities	13
Centers for Disease Control and Prevention	Promoting HIV, Viral Hepatitis, STDs, and LTBI Screening in Hospitals, Health Systems, and Other Healthcare Settings	344
Health Resources and Services Administration (subcontracted to AMA through American Heart Association, Inc.)	National Hypertension Control Initiative: Addressing Disparities Among Racial and Ethnic Minority Populations	577
Substance Abuse and Mental Health Services Administration (subcontracted to AMA through American Academy of Addiction Psychiatry)	Providers Clinical Support System Medicated Assisted Treatment	30
Government Funding		**2,810**
The Physicians Foundation, Inc.	American Conference on Physician Health	28
Nonprofit Contributors		**28**
Nuance Communications, Inc.	American Conference on Physician Health	12
Contributors less than $5,000	International Medical Graduates Section Reception	3
Other Contributors		**15**
Total Grants and Donations		**$ 2,853**

4. AMA 2025 DUES

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy G-635.130

Our American Medical Association (AMA) last raised its dues in 1994. The 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

2025 Membership Year

The Board of Trustees recommends no change to the dues levels for 2024, 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/Fellow Training	$ 45
Medical Students	$ 20

5. UPDATE ON CORPORATE RELATIONSHIPS

Informational report; no reference committee hearing.

HOD ACTION: FILED

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2023. Corporate activities that associate the American Medical Association (AMA) name or logo with a company, non-Federation association or foundation, or include commercial support, currently undergo review and recommendations by the Corporate Review Team (CRT) (Appendix A).

BACKGROUND

At the 2002 Annual Meeting, the HOD approved revised principles to govern the AMA's corporate relationships, HOD Policy G-630.040 "Principles on Corporate Relationships." These guidelines for American Medical Association corporate relationships were incorporated into the corporate review process, are reviewed regularly, and were reaffirmed at the 2012 and 2022 Annual Meeting. AMA managers are responsible for reviewing AMA projects to ensure they fit within these guidelines.

YEAR 2023 RESULTS

In 2023, 109 activities were considered and approved through the Corporate Review process. Of the 109 projects recommended for approval, 54 were conferences or events, 11 were educational content or grants, 32 were collaborations or affiliations, six were member programs, five were business arrangements/licensing programs and one was an American Medical Association Foundation (AMAF) program. See Appendix B for details.

CONCLUSION

The Board of Trustees (BOT) continues to evaluate the CRT review process to balance risk assessment with the need for external collaborations that advance the AMA's strategic focus.

APPENDIX A - Corporate Review Process Overview

The Corporate Review Team (CRT) includes senior managers from the following areas: Strategy, Finance, Health Solutions (HS), Advocacy, Office of the General Counsel, Medical Education, Publishing, Enterprise

Communications (EC), Marketing and Member Experience (MMX), Center for Health Equity (CHE), and Health, Science and Ethics.

The CRT evaluates each project submitted to determine fit or conflict with AMA Corporate Guidelines, covering:
- Type, purpose, and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA name and logo;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

The CRT reviews and makes recommendations regarding the following types of activities that utilize AMA name and logo:
- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.
- AMA sponsorship of external events.
- Independent and company-sponsored foundation supported projects.
- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks. This does not include database or Current Procedural Terminology (CPT ®) licensing.)
- Member programs such as new affinity or insurance programs and member benefits.
- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.
- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.
- Collaboration with academic institutions in cases where there is corporate sponsorship.

For the above specified activities, if the CRT recommends approval, the project proceeds.

In addition to CRT review, the Executive Committee of the Board must review and approve CRT recommendations for the following AMA activities:
- Any activity directed to the public with external funding.
- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Activities involving risk of substantial financial penalties for cancellation.
- Upon request of a dissenting member of the CRT.
- Any other activity upon request of the CRT.

All Corporate Review recommendations are summarized annually for information to the Board of Trustees (BOT). The BOT informs the HOD of all corporate arrangements at the Annual Meeting.

APPENDIX B - Summary of Corporate Review Recommendations for 2023

CONFERENCES/EVENTS

Project Number	Project Description	Corporations	Approval Date
21890	**March of Dimes Gourmet Gala -** Repeat sponsorship with AMA name and logo.	March of Dimes Samsung Proctor and Gamble Abbott Pharmaceuticals Barbour, Griffiths and Rogers Group PhRMA	01/24/2023

21930	**Bryce Harlow Foundation 42nd Annual Awards Dinner –** Sponsorship with AMA name and logo.	Bryce Harlow Foundation Canadian National Railway Company Society for Human Resource Management Fierce Government Relations AARP Holland & Knight	01/26/2023
21987	**HIMSS Global Health Conference & Exhibition -** Repeat sponsorship with AMA and CPT names and logos.	Health Information and Management Systems Society	02/02/2023
22011	**Public Relations Student Society of America Midwest District Conference –** Sponsorship with AMA name and logo.	Public Relations Student Society of America Public Relations Society of America	02/06/2023
22026	**NAMSS 47th Annual Educational Virtual Conference and Exhibition** - Repeat sponsorship with AMA name and logo.	National Association of Medical Staff Services ABMS Solutions American Board of Physician Specialties Columba Southern University DecisionHealth MD-Staff Medallion PreCheck Qgenda Silversheet Symplr The Greeley Company The Hardenbergh Group	02/07/2023
22039	**AHCJ Conference –** Repeat sponsorship with AMA and JAMA Network names and logos.	Association of Healthcare Journalists	02/08/2023

22132	**IAIABC 109th Convention -** Repeat sponsorship with AMA name and logo.	International Association of Industrial Accident Boards and Commissions National Council on Compensation Insurance Optum Sedgwick The Black Car Fund Concentra Aerie EDI Group Safety National Healthesystems Official Disability Guidelines by Milliman Clinical Guidelines Enlyte Ebix Verisk Tybera HealthTech, Inc Rising Medical Solutions	02/14/2023
22123	**AAPC HEALTHCON Events -** Repeat sponsorship with AMA name and logo.	American Academy of Professional Coders	02/15/2023
22064	**National Rx & Illicit Drug Summit -** Repeat sponsorship with AMA name and logo.	Operation Unite Police Treatment and Community Collaborative Georgia Council for Recovery Brevard Prevention Coalition Advantage Behavioral Health Emergency Medical Services World	02/16/2023
22120	**AMA Research Challenges-** AMA branded competition repeat event with Laurel Road sponsored prize.	Laurel Road Bank Key Bank	02/17/2023
22283	**National Black Law Students Association Convention –** Sponsorship with AMA name and logo.	National Black Law Students Association Haynes Boone Holland & Knight Alston & Bird	02/24/2023
22121	**Becker's Collaborations -** Webinar, CEO & CFO Roundtables and Luncheon, and Annual Hospital Review.	Becker's Hospital Review ASC Communications	02/24/2023
22194	**ViVE 2023 Sponsorship** – Repeat sponsorship with AMA name and logo.	HLTH Inc College of Healthcare Information Management Executives (CHIME)	03/02/2023

22323	**Rock Health Summit –** Repeat sponsorship with AMA name and logo.	Rock Health Foundation California Health Care Foundation Google Tulsa Innovation Labs 1501 Health BioReference Laboratories	03/06/2023
22209	**AMA International Medical Graduates Section (IMGS) Annual Meeting Desserts Reception –** Repeat sponsorship with AMA name and logo.	Association of Physicians of Pakistani Descent of North America Association of Haitian Physicians Abroad Korean American Medical Association National Arab Medical Association	03/09/2023
22353	**NLGJA: The Association of LGBTQ Journalists Annual Conference –** Repeat sponsorship with AMA name and logo.	AARP Warner Media Pulitzer Center Google News Lab Screen Actors Guild Walton Family Foundation EqualPride Media DotDash Meredith Publishing Craig Newmark Philanthropies Axios Media CoinDesk McClatchy Media Spectrum Networks Southern Newspaper Publishers Association Foundation	03/13/2023
22364	**Chicago Cares - Find your Cause Event** – Sponsorship with AMA name and logo.	Chicago Cares	03/15/2023
22462	**National Hispanic Medical Association 26th Annual Conference –** Repeat sponsorship with AMA name and logo.	National Hispanic Medical Association	03/17/2023
22454	**Asian American Journalists Association's Annual Convention** – Repeat sponsorship with AMA name and logo.	Asian American Journalists Association	03/20/2023

22540	**Credentialing State Shows –** Repeat sponsorship with AMA name and logo.	Texas Society for Medical Services Specialists Illinois Association of Medical Staff Services North Carolina Association of Medical Staff Services California Society for Medical Services Specialists MD Staff PreCheck Canadian International Medical Relief Organization Critical Incident Management Response Organization (CIMRO) Hardenbergh Group MD Review Qgenda YS Credentialing American Board of Medical Specialties Solutions	03/23/2023
22603	**Reuters Digital Health, Reuters Momentum Events** – Conference sponsorships with AMA name and logo.	Reuters Events	04/04/2023
22697	**AMA Medical Education AAMC Webinar –** Co-branded sponsorship with AMA name and logo.	Association of American Medical Colleges	04/14/2023
22707	**National Independent Laboratory Association Annual Meeting–** Repeat sponsorship with AMA name and logo.	Agena Bioscience Seegene Technologies Streamline Scientific TELCOR Quarles & Brady LLP	04/17/2023
22899	**Rush University Medical Center - West Side Walk for Wellness –** Repeat sponsorship with AMA name and logo.	Rush University Medical Center West Side Walk for Wellness	05/02/2023
22842	**National Multiple Sclerosis Society 45th Annual Ambassadors Ball –** Sponsorship with AMA name and logo.	National Multiple Sclerosis (MS) Society	05/05/2023
23081	**Essence Festival –** Sponsorship with In Full Health name and logo.	New Voices Foundation Essence Festival	05/23/2023

23152	**"Walking Backward into the Future of Chicago's West Side" Event –** Sponsorship with AMA name and logo.	Medical Justice in Advocacy Fellowship Morehouse School of Medicine	05/24/2023
23115	**The Systems Summit on Clinical Wellbeing at Princeton University -** Sponsorship with AMA name and logo.	Princeton Center for Health and Wellbeing The Samueli Foundation Kahneman-Treisman Center for Behavioral Science & Public Policy at Princeton Healing Works Foundation American College of Graduate Medical Education	06/08/2023
23441	**American Society of Bioethics and Humanities Conference** – Sponsorship with AMA Journal of Ethics name and logo.	American Society of Bioethics and Humanities	06/26/2023
23394	**National Adult and Influenza Immunization Summit –** Sponsorship with AMA name and logo.	Centers for Disease Control and Prevention Office of Infectious Disease and HIV/AIDS Policy U.S. Department of Health and Human Services Immunize.org	06/29/2023
23453	**NAACOS Fall Conference –** Sponsorship with AMA MAP name and logo.	National Association of Accountable Care Organizations	06/30/2023
23420	**SNOMED CT Expo** – Repeat sponsorship with AMA CPT and AMA names and logos.	Systematized Nomenclature of Medicine (SNOMED) International	07/06/2023
23656	**Chief Medical Officer Exchange** – Sponsorship with AMA name and logo.	HCPro HealthLeaders Nuance Healthcare Solutions 3M M*Modal Midmark	07/21/2023
23083	**ASMAC Fall Conference -** Sponsorship with AMA name and logo.	American Society of Medical Association Counsel	07/25/2023
23742	**American Conference on Physician Health** – Repeat sponsorship with AMA name and logo.	Stanford Medicine Mayo Clinic The Physician's Foundation Nuance Communications	07/27/2023

23838	**WOEMA Conference** - Sponsorship with AMA name and logo.	Western Occupational and Environmental Medical Association The Permanente Group Concentra Occupational Health e3 Occupational Health Solutions Novo Nordisk	08/02/2023
23865	**GCC eHealth Workforce Development Conference** – Repeat sponsorship with AMA name and logo.	Gulf Cooperation Council Emirates Health Services InterSystems Malaffi CyncHealth Dell Technologies	08/07/2023
23891	**CFHA Integrated Care Conference** – Repeat sponsorship with AMA name and logo.	Collaborative Family Healthcare Association	08/07/2023
23932	**Genetic Health Information Network Summit** - Repeat sponsorship with AMA name and logo.	Concert Genetics Illumina Sarah Lawrence Genomics Institute	08/14/2023
23939	**HMPRG Awards Gala –** Sponsorship with AMA name and logo.	Health & Medicine Policy Research Group Crown Family Philanthropies Cook County Health Joseph and Bessie Feinberg Foundation Rush Medical ACLU Illinois Chicago Bulls Chicago Federation of Labor Healthy Communities Foundation AgeOptions Erie Family Health Centers MiMedico Primary Care Thresholds ICAN!	08/15/2023
24037	**HLTH Conference** - Repeat sponsorship with AMA name and logo	HLTH Inc HLTH Foundation	08/17/2023

24059	**Alliance for Health Policy - Annual Dinner** – Repeat sponsorsorship with AMA name and logo.	Kaiser Permanente Otsuka Pharmaceuticals Blue Cross Blue Shield Association Elevance Health PhRMA American Hospital Association Amgen Catholic Health Association Patient Centered Outcomes Research Institute Merck Pharmaceuticals Better Medicare Alliance Amazon Shields Health Solutions Welsh-Carson-Anderson & Stowe ADVI Health	08/22/2023
24103	**29th Annual Princeton Conference** – Repeat sponsorship with AMA name and logo.	The Council on Health Care Economics and Policy at Brandeis University Association of American Medical Colleges AARP American Hospital Association Arnold Ventures Blue Cross Blue Shield of Massachusetts Foundation Blue Shield of California Foundation Booz Allen Hamilton California Health Benefits Review Program California Health Care Foundation Jewish Healthcare Foundation MAXIMUS Peterson Center on Healthcare The Health Industry Forum The John A. Hartford Foundation	08/25/2023
24096	**National Press Club's Newsmaker Series** – Sponsorship with AMA name and logo.	National Press Club	08/28/2023

24036	**APHC Conference Sponsorship** – Sponsorship with AMA name and logo.	Academy for Professionalism in Health Care Case Western Reserve University Cleveland Clinic: Lerner College of Medicine American Board of Medical Specialties Loma Linda University Health Johns Hopkins Berman Institute of Bioethics Loyola Bioethics American Association of Colleges of Osteopathic Medicine The Arnold P. Gold Foundation American Board of Internal Medicine Foundation Saint Louis University: Albert Gnaegi Center for Health Care Ethics	08/31/2023
23750	**NOAH Conference -** Sponsorship with AMA name and logo.	National Organization for Arts in Health Cleveland Clinic MetroHealth System Laurie M. Tisch Illumination Fund Museum Exchange Houston Methodist Hospital University of Rochester Stanford Medicine Aesthetics Inc. J.T. & Margaret Talkington College of Visual & Performing Arts at Texas Tech University Northwest Creative & Expressive Arts Institute	08/31/2023
24376	**National Addiction Treatment Week -** Repeat sponsorship with AMA name and logo.	American Society for Addiction Medicine Association of American Medical Colleges American College of Academic Addiction Medicine American Osteopathic Academy of Addiction Medicine Michigan Cares National Institute on Drug Abuse National Institute on Alcohol Abuse and Alcoholism University of California San Francisco Smoking Cessation Leadership Center	09/21/2023

24703	**Black Men in White Coats Youth Summit -** Repeat sponsorship with AMA name and logo.	Black Men in White Coats Veradigm Creating Pathways and Access for Student Success (CPASS) Foundation	10/16/2023
24839	**Women Business Leaders Annual Summit -** Repeat sponsorship with AMA name and logo.	Women Business Leaders Elevance Health Johnson & Johnson McKesson Corporation Tivity Health AMN Healthcare Epstein Becker & Green PC MCG Health Medecision CommonSpirit Health Mintz Law Firm Newport Healthcare ProgenyHealth UnitedHealth Group Aarete Consulting Firm Healthcare Leadership Council Hello Heart	11/03/2023
24773	**Hispanic Health Professional Student Scholarship Gala –** Sponsorship with AMA name and logo.	National Hispanic Health Foundation National Hispanic Medical Association	11/01/2023
25041	**HLTH Foundation Webinar -** Sponsorship with AMA name and logo.	HLTH Inc HLTH Foundation	11/20/2023
24941	**Consumer Electronics Show Digital Health Conference -** Sponsorship with AMA name and logo.	Consumer Technology Association American Psychological Association Connectivity Standards Alliance	11/22/2023
25305	**MD-Staff Educational Conference -** Sponsorship with AMA name and logo.	Applied Statistics & Management PreCheck The Hardenbergh Group Sterling Infosystems	12/07/2023

EDUCATIONAL CONTENT OR GRANT

Project Number	Project Description	Corporations	Approval Date
21752	**Words Matter-Making Sense of Health Equity Language Session –** Recording for Medscape's CME & Education platform with AMA name and logo.	Medscape Association of American Medical Colleges	01/10/2023
22334	**Parkinson's Foundation Education Series** - AMA EdHub hosted content with AMA name and logo.	Parkinson's Foundation CVS Health Foundation	03/22/2023
22712	**AMA STEPS Forward® Plan-Do-Study-Act (PDSA) Toolkit –** Update to toolkit hosted on AMA EdHub with AMA name and logo.	Center for Sustainable Health Care Quality and Equity National Minority Quality Form American College of Physicians	04/18/2023
23035	**Advancing AMA's Telehealth Policy Report –** Co-branded research report on telehealth priorities and trends, with AMA name and logo.	Manatt Health	05/30/2023
23094	**Future of Health Immersion Program** – Collaborators for AMA website program on telehealth.	The Physician's Foundation American Physical Therapy Association Health Choice Network Academy of Medicine of Cleveland and Northern Ohio	06/06/2023
23810	**Disability Inclusion in Undergraduate and Graduate Medical Education Modules -** AMA EdHub hosted content with AMA name and logo.	Association of Higher Education and Disability Docs with Disabilities Initiative Association of American Medical Colleges	08/01/2023
24016	**National Coalition for Sexual Health -** AMA EdHub hosted content with AMA name and logo.	National Coalition for Sexual Health Altarum Institute	09/07/2023
24576	**American Health Information Management Association Workshop –**Training on clinical documentation coding with AMA name and logo.	American Health Information Management Association	10/10/2023
24628	**Collaboration with Med Learning Group -** AMA EdHub hosted content with AMA name and logo.	Med Learning Group	10/26/2023

24905	**Credentialing School Sponsorship -** Repeat sponsorship with AMA name and logo.	Edge-U-Cate Certi-FACTS Symplr Federation of State Medical Boards	11/08/2023
24629	**Natural Resources Defense Council -** AMA EdHub hosted environmental health content with AMA name and logo.	Natural Resources Defense Council	11/10/2023

COLLABORATIONS/AFFILIATIONS

Project Number	**Project Description**	**Corporations**	**Approval Date**
21841	**National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience -** Sponsorship of stakeholder meeting series with AMA name and logo.	National Academy of Medicine National Academy of Sciences American Association of Colleges of Nursing	01/10/2023
21764	**Duke University Health AI Partnership (HAIP) –** Sponsorship of consortium and AI ethics training program with AMA name and logo.	Duke University Health Gordon and Bettey Moore Foundation DLA Piper LLC Hackensack Meridian Health Jefferson Health Kaiser Permanente Mayo Clinic Michigan Medicine New York-Presbyterian Parkland Center for Clinical Innovation UC Berkeley WellCare North Carolina	01/17/2023
24871	**MAP Dashboards for Health Care Organizations –** AMA co-branding with healthcare organizations for MAP blood pressure dashboard project.	University of South Alabama CommunityHealth Corewell Health	11/17/2023
21967	**American Telemedicine Association Membership –** Repeat sponsorship with AMA name and logo.	American Telemedicine Association	01/26/2023
21959	**HL7 CodeX Membership –** Collaboration for stakeholders on CodeX project with AMA name and logo.	Health Level Seven International	02/06/2023

25521	**Practice Transformation Survey Assessment Groups** – AMA co-branding with healthcare organizations for physician burnout survey project.	Intermountain Health – Montana Entira Family Clinics AdventHealth Dayton Children's Hospital Mountain Area Health Education Center ChenMed Sutter West Bay Medical Group Baptist Health South Florida Washington Permanente Medical Group CommUnity Care Sutter Health Margaret Mary Health Platte Valley Medical Center El Rio Health Children's Health of Orange County Scripps Health Cape Cod Hospital DaVita Health HealthOne PeaceHealth Rady Children's Hospital TidalHealth University of Toledo Medical Center UC Riverside School of Medicine Emergency Physicians of Tidewater Avera Health Arizona Alliance for Community Health Centers University of Michigan Health Providence Regional Medical Center Thundermist Behavioral Health Ochsner Health Cleveland Clinic Florida Geisinger Health Moffitt Cancer Center Gould Medical Group Beth Israel Deaconess Medical Center University of Tennessee Medical Center Cedars-Sinai Medical Center Inova Fairfax Medical Center The Center for Primary Care Honor Health Austin Health Partners Mercy Medical Center Oak Street Health University of Arkansas Health Center HarmonyCares Medical Group Franciscan Physician Network San Joaquin General Hospital St. Luke's Health System Baylor Scott and White Health Benefis Health System Hattiesburg Clinic Ridgecrest Regional Hospital Stamford Health Trinity Health Naples Community Healthcare North Country Healthcare	12/27/2023

25521 Cont'd	**Practice Transformation Survey Assessment Groups** – AMA co-branding with healthcare organizations for physician burnout survey project.	Jefferson Health Capital Region Medical Center Dayton Children's Hospital Missouri Association of Osteopathic Physicians and Surgeons Emergency Care Consultants Eskenazi Medical Group Sharp Community Medical Group Sturdy Memorial Hospital Kansas City University Medical School Owensboro Health National Cancer Care Alliance Louisiana State University Medical School Atrium Health Capital Region Medical Center Denver Health Emergency Care Consultants Erie Family Health Centers Health Access Network North Country Hospital Bryan Health Legacy Health Rogers Behavioral Health	
22118	**HLTH Foundation –** Sponsorship of equity research coalition and conference with AMA name and logo.	HLTH Foundation Ipsos Group S.A.	02/27/2023
22664	**MassChallenge HealthTech –** Sponsorship of healthcare startup mentorship program with AMA name and logo.	MassChallenge Lyda Hill Philanthropies Accenture Boston Children's Hospital Brigham Health and Women's Hospital	04/12/2023
22833	**"The PermanenteDocs Chat" Podcast Program -** Collaboration for bi-weekly podcast program with AMA name and logo.	The Permanente Federation Kaiser Permanente	04/20/2023

22820	**The Collaborative for Healing and Renewal in Medicine (CHARM) -** Charter committed to reducing healthcare worker burnout with AMA name and logo.	Alaska Native Medical Center Allegheny Health Network American Medical Women's Association Brigham & Women's Hospital CareMax ChenMed Children's Hospital of Los Angeles Dayton Children's Hospital Drexel University First Choice Community Healthcare HonorHealth Keck School of Medicine, University of Southern California Luminis Health Mercy Medical Center New York City Health Northwest Permanente PD Olive View-UCLA Medical Center Oregon Health & Science University Palo Alto Foundation Medical Group Piedmont Medical Center Pomona Valley Hospital Medical Center Queen's Health System Rogers Behavioral Health Roper St. Francis Healthcare St. Jude Heritage Medical Group St. Luke's Health System Stamford Hospital University of Michigan Health-West University of Texas Medical Branch US Acute Care Solutions Washington Permanente Medical Group Yale New Haven Hospital	05/01/2023
23018	**Rise to Health Coalition Collaborator Update –** Co-branded coalition to embed equity in healthcare including toolkits, webinars and guides for healthcare professionals.	National Committee for Quality Assurance American Association of Retired Persons American Nursing Association Bristol Myers Squibb	05/17/2023
23079	**National Health Equity Grand Rounds Collaborator Update -** Webinar series on health equity with AMA name and logo.	Social Mission Alliance	05/23/2023
23142	**National Association of Accountable Care Organizations Alliance Partner –** Membership to advance value-based care with AMA name and logo.	Primary Care Collaborative Center for Sustainable Healthcare National Association of Accountable Care Organizations Epic Systems Surescripts Blue Cross Blue Shield of South Carolina	05/25/2023

23292	**Improving Health Outcomes Research Collaboration -** UCSF feasibility study for wrist worn blood pressure monitoring devices.	University of California San Francisco LiveMetric	06/16/2023
23440	**Facility Closure Impact on Access to Maternity Care –** Co-branded research report regarding impact of facility closures on access to maternity care in Chicago.	March of Dimes Sinai Urban Health Institute	07/05/2023
23437	**Connecting to Coverage Coalition –** Outreach program collaboration to promote Medicaid enrollment with AMA name and logo.	America's Health Insurance Plans Thorn Run Partners	07/10/2023
23542	**VeriCre –** Pilot program collaboration for new AMA credentialing product with AMA name and logo.	Applied Statistics and Management MD-Staff SC Health Cleveland Clinic Boston Children's Hospital Mass General Brigham Council for Affordable Quality Healthcare HealthStream	07/14/2023
23512	**Health Equity in Organized Medicine Survey -**Collaboration on report summarizing survey findings with AMA name and logo.	MyWhy Agency	07/20/2023
23714	**Reuters Total Health –** Collaboration for report regarding industry challenges with AMA name and logo.	Reuters Kaiser Permanente GE Healthcare Dartmouth Health Sutter Health Ardent Health Center for Medicare Northwell Health	07/26/2023
24025	**Advancing Rural Behavioral Health Integration with Telehealth Research Program –** Collaborative study with AMA name and logo.	University of Hawaii John A. Burns School of Medicine The Physicians Foundation	08/18/2023

24404	**Joy in Medicine Health System Recognition Program -** Repeat AMA recognition program for outstanding healthcare organizations.	Baylor Scott & White – The Heart Hospitals (Denton, McKinney, Plano) Corwell Health EvergreenHealth Providence Medical Foundation: St. Joseph Heritage Medical Group St. Jude Heritage Medical Group Sturdy Health WellSpan Health Wellstar Health System Banner Health Connecticut Children's Dignity Health Arizona Market Family Health Centers of San Diego Hackensack Meridian Health Parkland Health Providence Health (Oregon) Reid Health Rush University Medical Center The Ohio State University Wexner Medical Center	09/25/2023
24250	**New MAP BP program distribution channel partner –** Collaboration to distribute MAP materials with AMA name and logo.	Altarum Institute	10/02/2023
24306	**Joint announcement for Social Needs Assessment Coder –** Press release to announce new program with AMA name and logo.	The Gravity Project	10/03/2023
24518	**Mathematica Physician Practice Information Survey –** Collaborative study on physician costs with AMA name and logo.	Mathematica	10/05/2023
24453	**Physician Data Collaborative –** Website launch with AMA name and logo.	Association of American Medical Colleges Accreditation Council of Graduate Medical Education	10/09/2023
24616	**MATTER Chicago –** Repeat sponsorship of nonprofit healthcare startup incubator with AMA name and logo.	Matter Chicago	10/10/2023
24558	**Prevention Strategy Collaboration with Health Care Organizations –** Update to program with AMA name and logo.	River Valley Family Healthcare	10/13/2023

24593	**Embedding Equity in Crisis Preparedness & Response in Health Systems Guide –** Update to materials with AMA name and logo.	Planned Parenthood Federation of America Reproductive Health Impact American Public Health Association New York City Pandemic Response Institute For the Culture Consulting, LLC	10/23/2023
24617	**VALID AI –** Membership in working group on AI in healthcare with AMA name and logo.	University of California Davis Health Moffit Cancer Center Cleveland Clinic Elevance MedStar Microsoft Google	10/23/2023
24714	**Physician Innovation Network (PIN) –** AMA PIN collaboration agreements with limited AMA name and logo use.	American Academy of Pain Medicine Microsoft Startup Accelerator	11/03/2023
24872	**Teaching Case on AMA's Center for Health Equity –** Collaboration to develop a case study with AMA name.	Harvard TH Chan School of Public Health	11/06/2023
24989	**Common Health Coalition: Together for Public Health –** Collaboration on pandemic preparedness with AMA name and logo.	America's Health Insurance Plans Alliance of Community Health Plans American Hospital Association Kaiser Permanente	11/15/2023
25403	**Henry Schein Cares Foundation "Prevention is Power" Initiative –** Collaboration on public health awareness campaign with AMA and Release the Pressure (RTP) names and logos.	Henry Schein Cares Foundation American Dental Association National Association of Community Health Centers CDC Foundation National Medical Association	12/06/2023

MEMBER PROGRAMS

Project Number	**Project Description**	**Corporations**	**Approval Date**
21990	**AHI Further –**Travel affinity program with AMA name and logo.	AHI Travel AHI Further Certares Management LLC	02/08/2023
23160	**PhysicianLoans –** Update to mortgage loan affinity program with AMA name and logo.	PhysicianLoans Huntington Bank	06/23/2023
23155	**AMBOSS Student & Resident Member Benefit –**Program for test prep discounts with AMA name and logo.	AMBOSS	06/29/2023
23376	**ClassPass Member Benefit –** Program for discounts on fitness classes with AMA name and logo.	ClassPass	06/30/2023

23161	**Headspace Member Benefit –** New member incentive for discounts on meditation app with AMA name and logo.	Headspace	06/30/2023
24014	**UptoDate, Inc. Member Benefit –** Program for discounts on software with AMA name and logo.	UptoDate, Inc	09/07/2023

BUSINESS ARRANGEMENTS/LICENSING PROGRAMS

Project Number	Project Description	Corporations	Approval Date
22809	**Teton Data Systems -** Licensing agreement for AMA content to be available through online reference service.	Teton Data Systems - Stat!Ref Online	05/15/2023
22944	**KnowledgeWorks Global PubFactory -** Licensing agreement for AMA content to be available through online reference service with AMA and AMA Guides names and logos.	KnowledgeWorks Global PubFactory	06/02/2023
23419	**LexisNexis - AMA Guides Content Integration -** Licensing agreement for AMA content to be available through online reference service with AMA and AMA Guides names and logos.	LexisNexis	06/29/2023
23827	**JAMA Network Content -** Licensing agreement for JAMA Network content to be available through online reference services with AMA name and logo.	Dot Lib Information, LLC Scite Inc Scholarly Network Security Initiative	07/31/2023
24369	**JAMA Network Worldwide –** Update to licensing agreements for AMA and JAMA Network content to be available through online reference services with JAMA Network name and logo.	Accucoms Inc Cactus CPL Data Licensing Alliance Inc USACO Corporation Nankodo Inc iGroup Asia Pacific Limited PSI IPV Limited Reprints Desk	09/26/2023

AMA FOUNDATION

AMA Foundation Corporate Donors – AMAF name and logo association with 2023 corporate donors.	AbbVie Amgen Boehringer-Ingelheim Bristol-Myers Squibb Daiichi Sankyo Eli Lilly Genentech GlaxoSmithKline Henry Schein Merck Novartis Pharmaceuticals Novo Nordisk Pfizer PhRMA Sanofi	05/03/2023

6. REDEFINING AMA'S POSITION ON ACA AND HEALTHCARE REFORM

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, "Redefining AMA's Position on ACA and Health Care Reform," which calls on our American Medical Association (AMA) to "develop a policy statement clearly outlining this organization's policies" on several specific issues related to the Affordable Care Act (ACA) as well as repealing the Sustainable Growth Rate (SGR) and the Independent Payment Advisory Board (IPAB). The adopted policy also calls for our AMA to report back at each meeting of the HOD. Board of Trustees Report 6-I-13, "Redefining AMA's Position on ACA and Health Care Reform," accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

IMPROVING THE AFFORDABLE CARE ACT

The AMA continues to engage policymakers and advocate for meaningful, affordable health care for all Americans to improve the health of our nation. The AMA remains committed to the goal of universal coverage, which includes protecting coverage for the now more than 20 million Americans who have acquired it through the ACA. The AMA has been working to fix the current system by advancing solutions that make coverage more affordable and expanding the system's reach to Americans who fall within its gaps. The AMA also remains committed to improving health care access so that patients receive timely, high-quality care, preventive services, medications, and other necessary treatments.

The AMA continues to advocate for policies that would allow patients and physicians to be able to choose from a range of public and private coverage options with the goal of providing coverage to all Americans. Specifically, the AMA has been working with Congress, the Administration, and states to advance the AMA plan to cover the uninsured and improve affordability as included in the "2022 and Beyond: AMA's Plan to Cover the Uninsured." The COVID-19 pandemic initially led to many people losing their employer-based health insurance. This only increased the need for significant improvements to the ACA. Subsequent data indicated that the uninsured rate eventually decreased during the COVID-19 pandemic, due to the temporary ACA improvements included in the American Rescue Plan Act, continuous Medicaid enrollment, and state Medicaid expansions.

The AMA also continues to examine the pros and cons of a broad array of approaches to achieve universal coverage as the policy debate evolves.

The AMA has been advocating for the following policy provisions:

Cover Uninsured Eligible for ACA's Premium Tax Credits

- The AMA advocates for increasing the generosity of premium tax credits to improve premium affordability and incentivize tax credit eligible individuals to get covered. Currently, eligible individuals and families with incomes between 100 and 400 percent federal poverty level (FPL) (133 and 400 percent in Medicaid expansion states) are being provided with refundable and advanceable premium tax credits to purchase coverage on health insurance exchanges.
- The AMA has been advocating for enhanced premium tax credits for young adults. In order to improve insurance take-up rates among young adults and help balance the individual health insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium tax credits could be provided with "enhanced" premium tax credits—such as an additional $50 per month—while maintaining the current premium tax credit structure that is inversely related to income, as well as the current 3:1 age rating ratio.
- The AMA is also advocating for an expansion of the eligibility for and increasing the size of cost-sharing reductions. Currently, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which leads to lower deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts. Extending eligibility for cost-sharing reductions beyond 250 percent FPL, and increasing the size of cost-sharing reductions, would lessen the cost-sharing burdens many individuals face, which impact their ability to access and afford the care they need.

Cover Uninsured Eligible for Medicaid or Children's Health Insurance Program

Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for Medicaid or the Children's Health Insurance Program (CHIP). Reasons for this population remaining uninsured include lack of awareness of eligibility or assistance in enrollment.

- The AMA has been advocating for increasing and improving Medicaid/CHIP outreach and enrollment, including auto enrollment.
- The AMA has been opposing efforts to establish Medicaid work requirements. The AMA believes that Medicaid work requirements would negatively affect access to care and lead to significant negative consequences for individuals' health and well-being.

Make Coverage More Affordable for People Not Eligible for ACA's Premium Tax Credits

Before the COVID-19 pandemic, in 2018, 5.7 million of the nonelderly uninsured were ineligible for financial assistance under the ACA, either due to their income, or because they have an offer of "affordable" employer-sponsored health insurance coverage. Without the assistance provided by ACA's premium tax credits, this population can continue to face unaffordable premiums and remain uninsured.

- The AMA advocates for eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent FPL.
- The AMA has been advocating for the establishment of a permanent federal reinsurance program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher premiums across the board in anticipation of higher-risk people enrolling in coverage. Section 1332 waivers have also been approved to provide funding for state reinsurance programs.
- The AMA also is advocating for lowering the threshold that determines whether an employee's premium contribution is "affordable," allowing more employees to become eligible for premium tax credits to purchase marketplace coverage.
- The AMA strongly advocated for the Internal Revenue Service regulation that was proposed on April 7, 2022 to fix the so-called "family glitch" under the ACA, whereby families of workers remain ineligible for subsidized ACA marketplace coverage even though they face unaffordable premiums for health insurance coverage offered through employers. The Biden Administration finalized the proposed rule on October 13, 2022. The regulation resolved the family glitch by extending eligibility for ACA financial assistance to only the family members of workers who are not offered affordable job-based family coverage.

EXPAND MEDICAID TO COVER MORE PEOPLE

Before the COVID-19 pandemic, in 2018, 2.3 million of the nonelderly uninsured found themselves in the coverage gap—not eligible for Medicaid, and not eligible for tax credits because they reside in states that did not expand Medicaid. Without access to Medicaid, these individuals do not have a pathway to affordable coverage.

The AMA has been encouraging all states to expand Medicaid eligibility to 133 percent FPL.

Policy adopted by the AMA HOD during the November 2021 Special Meeting seeks to assist more than two million nonelderly uninsured individuals who fall into the "coverage gap" in states that have not expanded Medicaid—those with incomes above Medicaid eligibility limits but below the FPL, which is the lower limit for premium tax credit eligibility. The new AMA policy maintains that coverage should be extended to these individuals at little or no cost, and further specifies that states that have already expanded Medicaid coverage should receive additional incentives to maintain that status going forward.

AMERICAN RESCUE PLAN OF 2021

On March 11, 2021, President Biden signed into law the American Rescue Plan (ARPA) of 2021. This legislation included the following ACA-related provisions that:

- Provided a temporary (two-year) five percent increase in the Federal Medical Assistance Percentage (FMAP) for Medicaid to states that enact the Affordable Care Act's Medicaid expansion and covered the new enrollment period per requirements of the ACA.
- Invested nearly $35 billion in premium subsidy increases for those who buy coverage on the ACA marketplace.
- Expanded the availability of ACA advanced premium tax credits (APTCs) to individuals whose income is above 400 percent of the FPL for 2021 and 2022.
- Gave an option for states to provide 12-month postpartum coverage under State Medicaid and CHIP.

ARPA represents the largest coverage expansion since the ACA. Under the ACA, eligible individuals, and families with incomes between 100 and 400 percent of the FPL (between 133 and 400 percent FPL in Medicaid expansion states) have been provided with refundable and advanceable premium credits that are inversely related to income to purchase coverage on health insurance exchanges. However, consistent with Policy H-165.824, "Improving Affordability in the Health Insurance Exchanges," ARPA eliminated ACA's subsidy "cliff" for 2021 and 2022. As a result, individuals and families with incomes above 400 percent FPL ($51,520 for an individual and $106,000 for a family of four based on 2021 federal poverty guidelines) are eligible for premium tax credit assistance. Individuals eligible for premium tax credits include individuals who are offered an employer plan that does not have an actuarial value of at least 60 percent or if the employee share of the premium exceeds 9.83 percent of income in 2021.

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

In addition, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which reduces their deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts.

LEGISLATIVE EXTENSION OF ARPA PROVISIONS

On August 16, 2022, President Biden signed into law the Inflation Reduction Act of 2022 through the highly partisan budget reconciliation process, which allows both the House and Senate to pass the bill with limits on procedural delays. Most significantly, reconciliation allows the Senate to bypass the filibuster and pass legislation with a 50-vote threshold so long as it meets a series of budgetary requirements. The Inflation Reduction Act included provisions that extended for three years to 2025 the aforementioned ACA premium subsidies authorized in ARPA.

The Inflation Reduction Act did not include provisions to close the Medicaid "coverage gap" in the states that have not chosen to expand.

ACA ENROLLMENT

According to the U.S. Department of Health and Human Services (HHS), 21.3 million people selected an Affordable Care Act Health Insurance Marketplace plan during the 2024 Open Enrollment Period. Total plan selections include more than five million people—about a fourth— who are new to the Marketplaces and 16 million people who renewed their coverage.

CONTINUOUS MEDICAID ENROLLMENT

During the COVID-19 pandemic, the Families First Coronavirus Response Act required states to provide continuous coverage to nearly all Medicaid/CHIP enrollees as a condition of receiving a temporary federal medical assistance percentage (FMAP) increase. With disenrollments frozen, churn out of the program effectively ceased and enrollment increased nationally by 35 percent, from 70,875,069 in February 2020 to 93,876,834 in March 2023, after which the continuous enrollment requirement was lifted. Most of this growth was in the Medicaid program, which increased by 22,634,781 individuals (35.3 percent), while CHIP enrollment increased during this period by 366,984 individuals (5.4 percent). The Consolidated Appropriations Act of 2023 (CAA), which was signed into law in December 2022, established March 31, 2023, as the end date for the Medicaid continuous enrollment requirement and phased down the enhanced FMAP amount through December 2023.
The CAA established new requirements that states must meet to receive the phased-down FMAP increase and gave CMS authority to require states to submit monthly unwinding data, such as the number of people whose coverage was terminated, the number of those terminated based on eligibility criteria versus for procedural reasons, plus call center volume and wait times. The CAA also authorized several enforcement mechanisms including corrective action plans, financial penalties, and requiring states to temporarily pause terminations.

The AMA continues to advocate that CMS ensure that states are maintaining Medicaid rate structures at levels that ensure sufficient physician participation, so that Medicaid patients can access appropriate, necessary care, including specialty and behavioral health services, in a timely manner and within a reasonable distance to where they live.

SGR REPEAL

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealing and replacing the SGR was signed into law by President Obama on April 16, 2015.

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

INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

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

CONCLUSION

Our AMA will remain engaged in efforts to improve the health care system through policies outlined in Policy D-165.938 and other directives of the HOD. Given that most of the ACA fixes that led to calls in 2013 for this report at every HOD meeting have been accomplished, our primary goal now related to health care reform is stabilization of the broken Medicare physician payment system, including the need for inflation-based positive annual updates and reform of budget neutrality rules.

7. AMA PERFORMANCE, ACTIVITIES, AND STATUS IN 2023

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

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

INTRODUCTION

The AMA's mission is to promote the art and science of medicine and the betterment of public health. As the physician organization whose reach and depth extend across all physicians, as well as policymakers, medical schools, and health care leaders, the AMA uniquely can deliver results and initiatives that enable physicians to improve the health of the nation.

Representing physicians with a unified voice

If the last few years have taught us anything it is that threats to the practice of medicine can come unexpectedly and from many fronts. In 2023 the AMA vigorously defended physicians and medicine in state and federal courts on a variety of issues threatening physicians and their patients. The AMA, in partnership with state medical associations and national medical specialty societies, won more than 100 state-level scope of practice cases.

Through research, advocacy and education, the AMA continued to defend the practice of medicine against scope of practice expansions that threaten patient safety. We promoted physician-led care and helped defeat legislation across the country that would have allowed:

- Physician assistants to practice independently without physician oversight
- Pharmacists to prescribe medications
- Optometrists to perform surgery
- Scope of practice expansion for nurse practitioners and other APRNs

The AMA facilitated 226,000+ contacts to Congress from patients and physicians as part of our FixMedicareNow.org grassroots campaign. To ensure more transparency in health care, the AMA worked with multiple state medical associations to introduce new or strengthen existing "Truth in Advertising" laws so that patients know if the person providing care to them is a physician—or not. Georgia and North Dakota enacted laws in 2023.

AMA's critical voice was represented in federal and state courts around the country on a broad range of issues, including in several cases before the U.S. Supreme Court. The AMA filed amicus briefs in: *Braidwood Management v. Becerra*, *Alliance for Hippocratic Medicine v. FDA*, and *Murthy v. Missouri*. Working with state and federal policymakers, the AMA continued to oppose legislation and laws that interfere with the practice of medicine, including in cases where physicians face criminal, civil, or administrative penalties for providing necessary care. In cases ranging from surprise billing, to firearm regulations to scope of practice, the AMA has aggressively fought back to protect physicians.

The AMA elevated the voice of physician leadership on critical issues of public health, securing more than 100 press releases, 125 billion media impressions representing nearly $1.2 billion in estimated ad value, achieving a commanding voice among healthcare entities in the media.

Removing obstacles that interfere with patient care

Physician burnout remains an ongoing epidemic in the U.S. and the AMA is fiercely committed to understanding the challenges physicians face and to restoring their well-being and optimism. We know that reducing burnout and promoting physician well-being are inextricably linked to the delivery of high-quality patient care and health system sustainability.

The AMA pushed forward in tackling the causes of burnout and in developing effective research and resources needed to help physicians achieve improved satisfaction and joy in their work. AMA published more than 25 peer-reviewed studies and over 2,000,000 users accessed the AMA STEPS Forward® program to prevent burnout and improve patient care and practice efficiency. AMA provided over 100 new or updated AMA STEPS Forward® resources – including toolkits, webinars, podcast episodes, and the new Wellness-Centered Leadership Playbook. AMA co-sponsored the 2023 American Conference on Physician Health with Stanford Medicine and Mayo Clinic in Palm Desert, California for over 600 attendees.

The AMA continued to expand its work in promoting physician wellness through its Joy in Medicine™ Health System Recognition Program. This program is committed to advancing the science of physician burnout and recognizes those systems that are dedicated to organizational well-being. In 2023 the AMA recognized 72 health systems – bringing the total number of recognized organizations to 96.

In 2023 the AMA worked with state medical associations across the country to enact prior authorization reform using AMA model legislation, data, testimony, and other resources that resulted in more than 30 states introducing legislation - and at least nine new states enacting prior authorization laws including AK, DC, IN, LA, MT, ND, NJ, RI, TN, and WA.

The AMA successfully piloted VeriCre, a cross-industry collaboration to improve the complex credentialing process for physicians, healthcare institutions, and health plans alike. VeriCre addresses inefficiencies in credentialing by providing centralized, trusted, and authoritative data that can be used to pre-populate applications. VeriCre is designed to be integrated into vendor software solutions within healthcare organizations.

The AMA worked to remove the barriers and end the stigma that all too frequently deters physicians from getting the mental health care they need. Our work with 15 state medical boards, health systems and credentialing bodies resulted in the removal of stigmatizing questions about mental illness from their applications.

Driving the future of medicine

The AMA achieved passage of legislation to extend Medicare telehealth coverage through 2024. The 2024 Medicare payment rule preserves key telehealth policies, ensuring Medicare patients from all areas of the country (not only rural) will continue to receive access to telehealth.
The AMA advanced a conceptual model for precision medical education: a system that can leverage technology and data to improve education personalization and learning efficiency across the continuum, in support of students, residents, fellows, physicians, and ultimately the
needs of patients. Innovation Grants were awarded to 13 sites applying precision education approaches in medical school, residency and continuing professional development.

The AMA ChangeMedEd® initiative and the University of Michigan developed a seven-part online learning module series introducing learners to foundational principles in artificial intelligence and machine-learning. The first of the series, Introduction to Artificial Intelligence (AI) in Health Care, launched on October 31 and was highlighted in a plenary session at the Association of American Medical Colleges Learn Serve Lead annual conference, spurring over 1600 page views and 65 course completions within the month of November alone.

AMA's influence continues through the Health Systems Science Scholars Program and the Coaching Implementation Workshop, with each program now having trained over 200 faculty members from across the US to advance these innovations in medical schools and residency programs.

AMA Ed Hub™ continued to expand its educational offering by signing on 14 new partners in 2023 - bringing the total number of partners to 50. The new partners include: American Association for Physician Leadership; American College of Occupational and Environmental Medicine; American College of Osteopathic Family Physicians; American Thoracic Surgery; Boston University; Docs with Disabilities; Endocrine Society; Mary Ann Liebert Publishers; Michigan State University; Parkinson's Foundation; Society of Critical Care Medicine; Radiology Health Equity Coalition; University of California, San Francisco, and Altarum Institute - National Coalition for Sexual Health.

AMA Ed Hub™, in collaboration with Advocacy and Health Science & Ethics, rapidly delivered an educational offering to help physicians and clinicians meet new DEA requirements on substance use disorders and addiction.

Including education from the AMA and their partners, this offering was deployed within 24 hours of the new regulation issuance and significantly contributed to increased AMA Ed Hub™ engagement.

To better meet the needs of academic researchers, *JAMA*® optimized the publication pathway by promising to move accepted manuscripts to publication within four weeks of submission for select manuscripts of high importance. *JAMA*® also launched a new video and podcast series on "AI and Clinical Practice" to keep physicians informed on AI's promise to transform treatment, training, research and publishing. *JAMA*® hosted its first JAMA Summit™ that brought together 60 experts from across the country and world to talk about why there is a big gap between the generation of evidence and what physicians do in clinical practice including what could we do to make it better.

The AMA's Center for Health Equity continues to strengthen physician and health system understanding and engagement around advancing equity. We launched the National Health Equity Grand Rounds, engaging almost 11,000 viewers around a variety of important topics and strategies to advance health equity and published 43 social justice education modules in the AMA Ed Hub™.

Leading the charge to confront public health crises

The AMA successfully advocated to make naloxone available over the counter and continued to advocate for responsible pricing and insurance coverage for this life-saving medication. We also successfully advocated for revisions to the Center for Disease Control's (CDC) opioid prescribing guidelines that resulted in the CDC removing its dose and quantity thresholds for treating patients with pain.

The AMA collaborated with three partners to increase access to AMA MAP™ metrics to improve the quality-of-care physicians provide to their patients with hypertension. Access to the metrics helps identify gaps, track progress, and support quality improvement efforts to reach approximately 5.5 million additional patients across 683 organizations inclusive of health systems, Federally Qualified Health Centers, community health centers and medical groups.

To help close a gap in blood pressure measurement training that exists within medical schools, the AMA awarded financial grants to eight academic institutions representing 18 total training programs for healthcare professionals allowing them to meaningfully engage in AMA's eLearning series, BP Measurement Essential: Student Edition.

The AMA's Enterprise Social Responsibility (ESR) program has strategically integrated and aligned to the health equity strategic framework with the goal to reduce health inequities in partnership with communities. The ESR program hosted over 30 events, supported nearly 70 organizations, and donated almost $100,000 to community partners. AMA employees, representing every business unit and office location, achieved 32 percent employee volunteer participation, far exceeding the industry average of 20 percent, to build healthy, thriving, equitable communities.

AMA Task Forces

The task force to Preserve the Patient-Physician Relationship was formed and has convened. The Board will submit an Informational Report at the 2024 Interim Meeting that will summarize the activities of this task force that have taken place to date.

The TRHT (Truth, Racial Healing, Transformation) task force was formed and has convened. The TRHT task force is on track to submit its recommendations to the AMA Board of Trustees by June 2025.

The Firearm Injury Prevention task force is convening and updates on its work are summarized in Board of Trustees Report 22-A-24.

The Substance Use and Pain Care task force is convening and updates on its work are summarized in Board of Trustees Report 22-A-24.

The Cannabis task force is convening and its work is focused on developing evidence-based education for physicians.

Membership

Overall, the organization's advocacy efforts and mission activities were supported by another strong year of financial performance. In 2023 the AMA experienced a 3.4% increase in overall dues-paying membership.

EVP Compensation

During 2023, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was $1,346,453 in salary and $1,117,107 in incentive compensation, reduced by $2,680 in pre-tax deductions. Other taxable amounts per the contract are as follows: $23,484 imputed costs for life insurance, $24,720 imputed costs for executive life insurance, and $4,000 paid for an executive physical, and $3,000 paid for parking and other. An $81,000 contribution to a deferred compensation account was also made by the AMA. This will not be taxable until vested and paid pursuant to provisions in the deferred compensation agreement.

For additional information about AMA activities and accomplishments, please see the "AMA 2023 Annual Report."

8. ANNUAL UPDATE ON ACTIVITIES AND PROGRESS IN TOBACCO CONTROL: MARCH 2023 THROUGH FEBRUARY 2024

Informational report; no reference committee hearing

HOUSE ACTION: FILED

This report summarizes trends and news on tobacco usage, policies, and tobacco control advocacy activities from March 2023 through February 2024. The report is written pursuant to American Medical Association (AMA) Policy D-490.983, "Annual Tobacco Report."

TOBACCO USE AT A GLANCE

In the 1960s the adult smoking rate was at its highest at 42 percent.[1] Today that rate has been cut by more than half to an all-time low in 2022 of 11 percent. Despite this decline, tobacco use remains the leading cause of preventable disease, disability, and death in the United States. According to the Centers for Disease Control and Prevention (CDC) cigarette smoking accounts for more than 480,000 deaths every year, or about 1 in 5 deaths. More than 16 million Americans live with a smoking-related disease.[2]

An annual review of tobacco use among adults, published in the May 5, 2023, Morbidity and Mortality Weekly Report (MMWR), summarizes National Health Interview Survey (NHIS) data to assess recent national estimates of commercial tobacco use among U.S. persons aged ≥18 years. NHIS is an annual, nationally representative household survey of the noninstitutionalized U.S. civilian population. Current smokers are defined as people who reported smoking at least 100 cigarettes during their lifetime and who, at the time they participated in a survey about this topic, reported smoking every day or some days. This analysis found an estimated 46 million U.S. adults (18.7 percent) reported currently using any tobacco product, including cigarettes (11.5 percent), e-cigarettes (4.5 percent), cigars (3.5 percent), smokeless tobacco (2.1 percent), and pipes (including hookah) (0.9 percent). Although cigarette smoking decreased, e-cigarette use increased, from 3.7 percent in 2020 to 4.5 percent in 2021, largely driven by higher prevalence in use among persons aged 18–24 years.[3]

Nearly one in five adults who currently used tobacco products used two or more products, with nearly one third of these individuals (31.4 percent) reporting use of cigarettes and e-cigarettes. Dual use of tobacco products may have overlapping adverse health effects. While smoking and vaping may share similar harmful cardiovascular effects, each appears to cause some potentially damaging effects that the other does not. This suggests that dual product use may be more harmful than using either product alone.[3,4]

The CDC and FDA analyzed data from the 2023 National Youth Tobacco Survey (NYTS) to assess tobacco product use patterns among U.S. middle school (grades 6–8) and high school (grades 9–12) students. This analysis was published in the November 3, 2023, MMWR.[5] The NYTS is a cross-sectional, school-based, self-administered web-based survey of U.S. middle and high school students. A stratified, three-stage cluster sampling procedure was used to generate a nationally representative sample of U.S. students attending private or public middle (grades 6–8) and

high (grades 9–12) schools. In 2023, data were collected during March 9–June 16; a total of 22,069 students from 179 schools participated, with an overall response rate of 30.5 percent.

Current use of any use of any tobacco product by high school students declined by an estimated 540,000, from 2.51 million in 2022 to 1.97 million in 2023. Declines were also reported for current e-cigarette use among high school students during that same period from 14.1 percent to 10.0 percent. While these declines demonstrate the effectiveness of tobacco control legislation and regulations, there is still cause for concern. E-cigarette products were the most used tobacco product of middle and high school students with 7.7 percent reporting current e-cigarette use followed by cigarettes at 1.6 percent. Among students who had ever used an e-cigarette, 46.7 percent reported current use and 89.4 percent of them used flavored products and 25.2 percent used an e-cigarette daily. Given the number of middle and high school students that use tobacco products, sustained efforts to prevent initiation of tobacco product use among young persons and strategies to help young tobacco users quit are critical to reducing U.S. youth tobacco product use.**Error! Bookmark not defined.**

Sales Use of E-Cigarettes Dominated by Flavored Products

E-cigarette unit sales increased by 46.6 percent during January 2020–December 2022 according to a study released by the truth initiative®. The study E-cigarette Unit Sales by Product and Flavor Type, and Top-Selling Brands, United States, 2020–2022 was published in the June 23, 2023, MMWR.[6] From January 26, 2020, to December 25, 2022, unit shares of tobacco-flavored and mint-flavored products decreased (from 28.4 percent to 20.1 percent and from 10.1 percent to 5.9 percent, respectively), whereas shares of other flavor sales increased (from 29.2 percent to 41.3 percent).[6]

The study authors also looked at types of e-cigarettes. Disposable e-cigarettes are the preferred delivery device for vaped tobacco. Sales of fruit- and mint-flavored disposable products saw a significant rise compared to refillable cartridge devices. During the study period, January 2020–December 2022, sales of prefilled cartridges decreased from 75.2 percent to 48.0 percent, and disposable e-cigarette sales increased from 24.7 percent to 51.8 percent. The authors attributed this to an announcement in January 2020 by the U.S. Food and Drug Administration (FDA) that the agency would prioritize enforcement against prefilled e-cigarettes in flavors other than tobacco and menthol based on the prevalence of use of these products by youth.

In the United States, the prevalence of e-cigarette use is markedly higher among youths and young adults than it is among adults overall. In 2021, 4.5 percent of all adults aged ≥18 years (an estimated 11.1 million) and 11.0 percent of young adults aged 18–24 years (an estimated 3.1 million) currently (≥1 day during the previous 30 days) used e-cigarettes; during 2022, 14.1 percent of high school students (an estimated 2.14 million) currently used e-cigarettes. The unit share of menthol-flavored product sales remained relatively stable, while non-menthol flavor unit shares changed.[6]

EFFORTS TO ADDRESS TOBACCO CONTROL

AMA Litigation Center joins with public health groups to protect tobacco regulation

In the courts, the AMA has continued to be very active in supporting efforts to further regulate and limit tobacco products and electronic nicotine delivery systems (ENDS). The AMA has joined numerous amicus briefs around the country in cases involving the federal government’s efforts to regulate and remove flavored ENDS from the market, which have contributed to favorable outcomes in several federal circuit courts. In addition, the AMA has supported state and local governments with friend-of-the-court briefs after their laws banning flavored tobacco products and ENDS have been challenged by the tobacco and vaping industry. Finally, the AMA continues to monitor the federal government's efforts to eliminate the manufacture and sale of tobacco products with characterizing flavors, including menthol, as the AMA was one of the named plaintiffs in a lawsuit requiring the FDA to take long-overdue action on this issue.

The AMA Litigation Center joined amicus briefs in Oregon supporting the ability of two counties to regulate flavored tobacco products beyond the state-level restrictions. The court cases centered on whether a county ordinance banning the sale of flavored tobacco products conflicts with a state law regulating the sale of tobacco and nicotine. One of the counties received a favorable ruling, and the other matter remains pending.

The Litigation Center also joined an amicus brief supporting the use of graphic warnings on tobacco products. The issue in R.J. Reynolds v. FDA is whether an FDA rule regarding graphic warnings on cigarettes is lawful. That case remains pending.

AMA urged the FDA to investigate violations of federal law in California

In December 2022 California's law prohibiting the sales of menthol cigarettes and other flavored tobacco products prevailed despite legal challenges. California became the largest state in the country banning these products and became the target for release of new products designed to circumvent the law. R.J. Reynolds announced two new brands, Camel Crisp Non-Menthol and Camel Crush Oasis Non-Menthol Capsule.

The Tobacco Control Act, which gives the FDA authority to regulate the tobacco industry prohibits the introduction of new products that have not undergone remarket review by the FDA. The introduction and marketing of the R.J. Reynolds products and others as "substitutes" for menthol cigarettes rather than "new" products suggests that the industry believes it has found a loophole.

In March 2023 the AMA joined by other medical, public health and community organizations urged the FDA to use its authority and begin an investigation.

Helping Tobacco Users Quit Act would expand and ensure cessation coverage

In July 2023 Congresswoman Lisa Blunt Rochester (D-Del.) and Congressman Brian Fitzpatrick (R-Penn.) introduced the Helping Tobacco Users Quit Act. This bi-partisan bill, supported by the AMA, calls for expanded comprehensive Medicaid tobacco cessation coverage in every state with no cost-sharing or access barriers for beneficiaries. The bill would also help states conduct outreach campaigns to educate providers and beneficiaries about Medicaid's coverage of cessation services.

The bill was referred to the House Energy and Commerce Subcommittee on Health waiting for a hearing and further consideration. Medicaid enrollees smoke at twice the rate of those with private insurance, meaning that expanding cessation coverage in Medicaid would improve health outcomes while lowering government spending.[7]

American Lung Association Releases its 2024 State of Tobacco Report

The American Lung Association's 2024 "State of Tobacco Control" report reveals the continued impact of tobacco use, including menthol cigarettes, on individuals and families across the country, and underscores the urgent need for the White House to finalize the rules to end the sale of menthol cigarettes and flavored cigars to save lives.[8] The report highlighted the tobacco industry and its allies' influence to successfully convince the White House to delay finalizing the menthol cigarettes and flavored cigars rules.
Since the 1950s, Black individuals have been successfully targeted by aggressive marketing campaigns. According to a study in the 2023 April issue of *Nicotine & Tobacco Research*, an estimated 80 percent of Black individuals in the U.S. who smoke prefer menthol cigarettes. The authors also noted that target marketing was having an impact on Hispanic adults. During the study period the use of menthol went from 34 percent in 2008 to 51 percent in 2020.[9]

At the local level, Chicago, IL and Milwaukee, WI were highlighted in the report for actions taken to restrict where new tobacco retailers can locate. This legislative action takes aim at the increased concentration of tobacco product retailers in low-income neighborhoods.

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9. COUNCIL ON LEGISLATION SUNSET REVIEW OF 2014 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED

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

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

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

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

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

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

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

RECOMMENDATION

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

APPENDIX – Recommended Actions

Policy Number	**Title**	**Text**	**Recommendation**
D-105.996	Impact of Pharmaceutical Advertising on Women's Health	1. Our AMA urges the US Food and Drug Administration (FDA) to assure that all direct-to-consumer advertising of pharmaceuticals includes information regarding differing effects and risks between the sexes. 2. Our AMA urges the FDA to assure that advertising of pharmaceuticals to health care professionals includes specifics outlining whether testing of drugs prescribed to both sexes has included sufficient numbers of women to assure safe use in this population and whether such testing has identified needs to modify dosages based on sex. (Res. 509, A-14)	Retain – this policy remains relevant.
D-115.988	Medication Non-Adherence and Errors	Our AMA will recommend the Centers for Medicare & Medicaid Services conduct a cost/benefit analysis and an analysis of the ability of seniors and people with disabilities to use blister packs in order to determine the feasibility of expanding coverage for timed calendar blister packs for prescription medications beyond residents of long term care facilities. (BOT Rep. 11, A-14)	Sunset this policy. The recommendation was communicated to the Centers for Medicare & Medicaid Services.
D-120.944	Improvement of Electronic Prescription Software	Our AMA will~~: (1) advocate for changing the national standards for controlled substance prescriptions so that prescriptions for controlled substances can be transmitted electronically directly to the pharmacy in a secure manner; and (2)~~ work with pharmacies, vendors, and other appropriate entities to encourage the use of standards that would allow the transmission of short messages regarding prescriptions so that both physicians and pharmacists could communicate directly with each other within the secure health records systems that they are already using. (Res. 209, A-14)	Retain this policy in part. Delete clause (1). Drug Enforcement Administration regulations allow the option of writing prescriptions for controlled substances electronically. The regulations also permit pharmacies to receive, dispense, and archive these electronic prescriptions.
D-120.980	Regulation of Media-Based Drug Sales Without Good Faith Medical Examination	Our AMA will develop and promote model federal legislation to eliminate the sale, without a legitimate prescription, of prescription drugs over the Internet, if such	Sunset this policy. This policy has been superseded by more recent

Policy Number	Title	Text	Recommendation
		bills to establish national standards in this area are not forthcoming. (Sub. Res. 520, A-04; Reaffirmed: BOT Rep. 19, A-14)	AMA policy (H-120.956, Internet Prescribing).
D-130.971	The Future of Emergency and Trauma Care	Our AMA will: (1) expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care; (2) with the advice of specific specialty societies, advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties; (3) continue to advocate for the following: a. Insurer payment to physicians who have delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status, b. Financial support for providing EMTALA-mandated care to uninsured patients, c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service, d. Federal and state liability protections for physicians providing EMTALA-mandated care; (4) disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation; (5) support demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care; (6) support the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by such extension; and (7) if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by extension of the FTCA, our AMA will conduct a legislative campaign, coordinated with national specialty societies,	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		targeted toward extending FTCA protections to all EMTALA-mandated care, and the AMA will assign high priority to this effort. (BOT Rep. 14, I-06; Reaffirmation A-07; Reaffirmation A-08; BOT action in response to referred for decision Res. 204, A-11; Appended: Res. 221, I-11; Modified: CCB/CLRPD Rep. 2, A-14)	
D-130.976	Implications of the November 2003 Emergency Medical Treatment and Labor Act (EMTALA) Final Rule	Our AMA will: (1) ask the EMTALA Technical Advisory Group (TAG) and the Centers for Medicare and Medicaid Services (CMS) for assistance in ameliorating the differential economic and staffing burdens on certain categories of facilities, including but not limited to academic health centers, trauma centers, critical access hospitals, and safety net hospitals, which are likely to receive high volumes of patients as a result of the EMTALA regulations; (2) work with the EMTALA TAG and CMS to ensure that physicians staffing emergency departments and on-call emergency services be appropriately compensated for providing EMTALA mandated services; (3) with input from all interested Federation members, coordinate an effort to educate the membership about emergency department coverage issues and the efforts to resolve them; (4) seek to require all insurers, both public and private, to pay promptly and fairly all claims for services mandated by EMTALA for all plans they offer, or face fines and penalties comparable to those imposed on providers; and (5) seek to have CMS require all states participating in Medicaid, as a condition of continued participation, establish and adequately fund state Emergency Medical Services funds which physicians providing EMTALA-mandated services may bill, and from which those physicians shall receive prompt and fair compensation. (CME Rep. 3, A-05; Reaffirmation A-07; Reaffirmed in lieu of Res. 605, I-08; Modified: CCB/CLRPD Rep. 2, A-14)	Retain – this policy remains relevant.
D-160.991	Licensure and Liability for Senior Physician Volunteers	Our AMA (1) and its Senior Physician Group will inform physicians about federal and state-based charitable immunity laws that protect physicians wishing to volunteer their services in free medical clinics and other venues; and (2) will work with organizations representing free clinics to promote opportunities for physicians who wish to volunteer.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(BOT Rep. 17, A-04; Reaffirmed: CCB/CLRPD Rep. 1, A-14)	
D-175.985	The CMS Electronic Medical Records Initiative Should Not Be Used To Detect Alleged Fraud by Physicians	~~1. Our AMA will (A) communicate its concerns about the plan recently announced by the Centers for Medicare and Medicaid Services (CMS), in which CMS is to use data from the electronic medical record incentive program in the pursuit of fraud, waste and abuse; and (B) seek active involvement in the drafting of all program directives for CMS's electronic medical record initiative, including all directives about potential data capture and subsequent audit processes.~~ ~~2. Our AMA will lead an effort in concert with the Centers for Medicare and Medicaid Services to establish specific guidance to be utilized by entities that audit documentation generated by an electronic health record.~~ ~~3. Such guidance will provide specific protocols used by Medicare and Medicaid auditors to allege a service is not reasonable and necessary based on the generation of an electronic health record.~~ ~~4. Our AMA will inform state and specialty societies about available AMA resources to assist physicians with audits of electronic health records and prominently feature on their website information about methods, resources, and technologies related to appeals of electronic health record audits and Medicare and Medicaid overpayment recoveries as a members-only benefit.~~ ~~5~~1. Our AMA believes that the use of time-saving features, such as cloning, templates, macros, "pull forward technology", auto-population and identical language in EMRs, by itself is not an indication of inaccurate documentation or incorrect coding. ~~6~~2. Our AMA believes that audit results that imply incorrect coding must specifically indicate which portion of the chart language either does not accurately reflect the office visit or reflects unnecessary care. ~~7~~3. Our AMA will: ~~(1) develop guidelines in conjunction with the Centers for Medicare & Medicaid Services to provide clear and direct guidance to physicians concerning the permissible use for coding and billing of electronic health record (EHR) clinical documentation tools, such as templates, macros, cutting and pasting, and cloning, and (2)~~ study the impact of EHR clinical documentation tools and shortcuts on patient safety, quality of care and safe harbor laws.	Retain this policy in part. Delete clauses (1) - (4) and modify clause (7). Our AMA communicated these concerns to the Centers for Medicare & Medicaid Services.

Policy Number	Title	Text	Recommendation
		(Res. 212, A-10; Appended: Res. 206, I-11; Appended: Res. 715, A-13; Reaffirmed: BOT Rep. 20, A-14)	
D-215.995	Specialty Hospitals and Impact on Health Care	Our AMA will: (1) oppose efforts to either temporarily or permanently extend the 18-month moratorium on physician referrals to specialty hospitals in which they have an ownership interest; (2) support changes in the inpatient and outpatient Medicare prospective payment systems to eliminate the need for cross-subsidization by more accurately reflecting the relative costs of hospital care; (3) support federal legislation and/or regulations that would fix the flawed methodology for allocating Medicare and Medicaid Disproportionate Share Hospital (DSH) payments to help ensure the financial viability of safety-net hospitals so they can continue to provide adequate access to health care for indigent patients; (4) encourage physicians who contemplate formation of a specialty hospital to consider the best health interests of the community they serve. Physicians should explore the opportunities to enter into joint ventures with existing community hospitals before proceeding with the formation of a physician-owned specialty hospital; and (5) oppose the enactment of federal certificate of need (CON) legislation and support state medical associations in their advocacy efforts to repeal current CON statutes and to oppose the reinstatement of CON legislation or its expansion to physician-owned ambulatory health care facilities. (BOT Rep. 15, I-04; Reaffirmation A-09; Modified: CCB/CLRPD Rep. 2, A-14)	Retain – this policy remains relevant.
D-255.985	Conrad 30 - J-1 Visa Waivers	1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program. 2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program. 3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs. 4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses. 5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria. (Res. 233, A-06; Appended: CME Rep. 10, A-11; Appended: Res. 303, A-11; Reaffirmation I-11; Modified: BOT Rep. 5, I-12; Appended: BOT Rep. 27, A-13; Reaffirmation A-14)	
D-255.993	J-1 Visas and Waivers	1. Our AMA shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program. ~~2. If the USDA does not continue in its role as an interested government agency (IGA), the AMA encourage HHS to expand its J-1 visa waiver program.~~ ~~3~~2. Our AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians~~?~~' service requirements through the J-1 waiver and Conrad-30 programs~~ with a report back at A-03~~.	Retain this policy in part. Delete clause (2) and modify clauses (3) – (5). In 2002 the USDA decided to discontinue its role as an IGA on behalf of foreign research scientists or physicians desiring a recommendation of a J-1Visa waiver. Moreover, HHS has already expanded its J-1 visa waiver program.

Policy Number	Title	Text	Recommendation
		43. Our AMA will work towards regulation and/or legislation to allow physicians on H-1B waiver visas ~~for their J-1 visa waiver~~, who are limited to serving in medically underserved areas, to continue to care for their patients who require hospitalization in the closest appropriate medical facility which may not be in the underserved area. ~~5~~4. Our AMA ~~will work with state medical societies to study and report back on the feasibility of having~~ support a national data repository of J-1 Visa Waiver statistics so that J-1 Visa Waiver unoffered positions can be transferred to states as needed to treat underserved communities and to monitor the success of this program. (BOT Rep. 11, I-02; Appended: Res. 324, A-11; Appended: Res. 904, I-11; Reaffirmation A-14)	
D-260.994	Point of Care Availability for Blood Glucose Testing	Our AMA will work with the Food and Drug Administration and the Centers for Medicare & Medicaid Services to maintain the Clinical Laboratory Improvement Act exempt status of point-of-care glucose testing. (Res. 727, A-14)	Sunset this policy. Our AMA communicated support to the U.S. Food and Drug Administration and the Centers for Medicare & Medicaid services for Clinical Laboratory Improvement Amendments exempt status of point of care blood glucose testing.
D-315.984	Ownership of Claims Data	Our AMA will: (1) encourage physicians to include language designed to buttress rights associated with claims data ownership and access when contracting with health plan payers and other third parties; (2) continue to educate physicians on providing public and private health plan payers the "minimum necessary," as defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and regulations thereunder, protected health information necessary to achieve the purpose of a disclosure; (3) assist physicians wishing to register a complaint against health plan payers that have used claims data to form a database, or that have permitted access to or sale of the database or its contents without explicit patient and/or physician authorization, beyond the scope permitted by HIPAA with the Department of Health and Human Services Office of Civil Rights; (4) advocate to the Department of Health and Human Services, Office of the National Coordinator of Health Information Technology and/or other appropriate agencies for rules and regulations ensuring	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		appropriate physician ownership and access rights to claims data, and appropriate protection of claims data held by various parties; and (5) continue to monitor federal and state activities impacting the exchange of physician-generated health information, including claims data. (BOT Rep. 19, I-06; Modified: CCB/CLRPD Rep. 2, A-14)	
D-35.994	Scope of Practice Participants in Health Plans	Our AMA Advocacy Resource Center will work at the invitation of AMA component societies to oppose legislative mandates on health care plans that may lead to inappropriate scope of practice expansion of non-physician providers. (Res. 923, I-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
D-375.997	Peer Reviewer Immunity	Our AMA will: (1) recommend medical staffs adopt/implement staff by laws that are consistent with HCQIA and AMA policy by communicating the guidelines from AMA policy H-375.983 widely through appropriate media to the relevant organizations and institutions, including a direct mailing to all medical staff presidents in the United States, indicating that compliance is required to conform to HCQIA and related court decisions; (2) monitor legal and regulatory challenges to peer review immunity and non discoverability of peer review records/proceedings and continue to advocate for adherence to AMA policy, reporting challenges to peer review protections to the House of Delegates and produce an additional report with recommendations that will protect patients and physicians in the event of misdirected or negligent peer review at the local level while retaining peer review immunity for the process; and (3) continue to work to provide peer review protection under federal law. (BOT Rep.8, I-01; Reaffirmation A-05; Modified: CCB/CLRPD Rep. 2, A-14)	Retain – this policy remains relevant.
D-40.995	The Implications of Health Care Personnel Delivery System	Our AMA will continue to monitor the Health Care Personnel Delivery System (HCPDS) and initiate communication with the Selective Service System and other relevant governmental bodies to address questions and concerns related to the implementation of the HCPDS. (CME Rep. 2, I-04; Reaffirmed: CMS Rep. 1, A-14)	Retain – this policy remains relevant.
D-400.984	Transparency, Participation, and Accountability in	1. Our AMA will urgently advocate for the Centers for Medicare and Medicaid Services (CMS) to improve its rate-setting processes	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
	CMS' Payment Determination Process	by first publishing modifications to Medicare physician fees that result from CMS' misvalued codes initiative in the Medicare Physician Fee Schedule proposed rule instead of the final rule to afford adequate time for providers, professional medical societies and other stakeholders to review and comment on such changes before they take effect. 2. Our AMA will demand that CMS be transparent in its processes and methodologies for establishing physician work values and allow adequate opportunity for public comment on its methodologies before changes in physician work values take effect. (Res. 220, A-14)	
D-406.998	National Provider Identification	Our AMA will work closely in consultation with the Centers for Medicare and Medicaid Services to introduce safeguards and penalties surrounding the use of National Provider Identification to protect physicians' privacy, integrity, autonomy, and ability to care for patients. (Res. 717, I-04; Reaffirmed: CMS Rep. 1, A-14)	Retain – this policy remains relevant.
D-435.978	Loss of Medical Staff Privileges for Lack of "Tail Coverage"	Our AMA will: (1) Advocate for better disclosures by professional medical liability insurance carriers to their policyholders about the continuing financial health of the carrier; and advocate that carriers create and maintain a listing of alternate professional liability insurance carriers in good financial health which can provide physicians replacement tail or other coverage if the carrier becomes insolvent; and (2) Support model medical staff bylaw language stating: "Where continuous professional liability insurance coverage is a condition of medical staff membership, a temporary loss of professional liability insurance coverage (whether or not limited to "tail" coverage) is not grounds for immediate termination of medical staff membership. The Medical Executive Committee shall determine the length and other conditions of an individual waiver of the coverage requirement." (BOT Action in response to referred for decision Res. 537, A-04; Modified: CMS Rep. 1, A-14)	Retain – this policy remains relevant.
D-435.985	Use of Countersuits to Discourage Frivolous Lawsuits	Our AMA will advise members of the option for countersuits against plaintiffs and attorneys who have filed frivolous lawsuits against physicians.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(Sub. Res. 914, I-04; Reaffirmed: BOT Rep. 19, A-14)	
D-440.933	VA ACES Travel Policy	Our AMA will send a letter to the Secretary of the Department of Veterans Affairs (VA) and any other appropriate entities noting that the Attendance and Cost Estimation System (ACES) system has become a barrier to VA physician attendance at medical and scientific meetings, and encourage the Secretary to adopt ACES system reforms that will allow VA employed physicians to attend medical and scientific conferences. (Res. 614, A-14)	Sunset this policy. Our AMA submitted a letter to the Department of Veterans Affairs advocating for ACES reforms to lower the barriers and make it easier for VA-employed physicians and researchers to attend medical and scientific conferences.
D-440.934	Onerous Restrictions on Travel of Government Scientists	Our AMA ~~will pursue legislative or regulatory action to achieve~~ supports easing ~~of~~ travel restrictions for federally-employed scientists who are attending academic or scientific conferences that are consistent with current HHS policies and procedures, to include a simplified approval process. (Res. 608, A-14)	Retain this policy in part. Our AMA has communicated to the federal government about easing and simplifying restrictions related to federally employed scientists attending academic and scientific conferences.
D-450.959	Improvements to the Value-Based Modifier	Our AMA will: (1) seek a delay in the Value-Based Modifier (VBM) penalty for smaller practices; and (2) continue to encourage selection of VBM quality measures that are physician-defined, clinically meaningful, specialty-appropriate, realistic, and within reasonable control of the physician. (Sub. Res. 218, A-14)	Sunset this policy. The Value-Based Modifier program was replaced by the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program.
D-450.981	Protecting Patients Rights	Our AMA will: (1) continue to advocate for the repeal of the flawed sustainable growth rate formula without compromising our AMA's principles for pay-for-performance; and (2) develop a media campaign and public education materials to teach patients and other stakeholders about the potential risks and liabilities of pay-for-performance programs, especially those that are not consistent with AMA policies, principles, and guidelines. (Modified: CCB/CLRPD Rep. 2, A-14)	Sunset this policy. The sustainable growth rate was repealed by the Medicare Access and CHIP Reauthorization Act.
D-450.987	Support of Patient Safety Aspects of The Joint Commission	Our AMA will continue to work with The Joint Commission on the development of standards which improve patient safety; and our AMA and The Joint Commission will then present these changes to the Centers for Medicare & Medicaid Services to effect an update of good health care policy and to delete outdated wasteful health care policy. (Res. 530, A-04; Modified: CMS Rep. 1, A-14)	Retain – this policy remains relevant.
D-480.973	President's Council on Science and Technology Report	Our AMA will analyze the President's Council on Science and Technology Report entitled "Better Health Care and Lower	Sunset this policy.

Policy Number	Title	Text	Recommendation
		Costs: Accelerating Improvement through Systems Engineering" and respond as appropriate. (Res. 523, A-14)	Our AMA thoroughly analyzed the May 2014 President's Council on Science and Technology Report (PCAST) and has taken steps to implement the recommendations through testimony to an Office the National Coordinator Federal Advisory Committee, public comment on ONC's proposed 10-year health IT roadmap, and comment letters to the Administration in support of the health IT framework outlined in the November 2014 Report to the President: Better Health Care and Lower Costs: Accelerating Improvement Through Systems Engineering.
D-60.968	Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth	Our AMA will work with medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being, and (ii) secure federal, state, and other funding sources to support those services. (Res. 8, I-14)	Retain – this policy remains relevant.
D-80.997	Identify Theft	~~1.~~ Our AMA will request that the Internal Revenue Service (IRS) adopt policies to ensure greater security protection for electronically filed federal income tax returns, including the universal use of PINs, or personal identification numbers. ~~2. Our AMA will request that the IRS and the Centers for Medicare & Medical Services promulgate regulations to prohibit the use of Social Security numbers (SSN) by insurers, health care vendors, state agencies other than the state taxing authority and non-financial businesses.~~ (Res. 613, A-14)	Retain this policy in part. Delete clause 2. In 2023, the Centers for Medicare & Medicaid Services removed SSN-based health insurance claim numbers from Medicare cards and is now using Medicare Beneficiary Identifiers (MBIs) for Medicare transactions like billing, eligibility status, and claim status.
H-110.998	Cost of New Prescription Drugs	Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs. (Res. 112, I-89; Reaffirmed: Res. 520, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 229, I-14)	Sunset this policy. This policy has been superseded by more recent AMA policy (H-110.987, Pharmaceutical Costs; H-110.988, Controlling the Skyrocketing Costs of Generic Prescription Drugs;

Policy Number	Title	Text	Recommendation
			H-110.997, Cost of Prescription Drugs; H-285.965, Managed Care Cost Containment Involving Prescription Drugs; H-110.997, Cost of Prescription Drugs).
H-120.937	Methadone Should Not Be Designated as the Sole Preferred Analgesic	Our AMA recommends that methadone should not be designated as the sole preferred analgesic by any insurance payer, whether public or private. (Res. 117, A-14)	Sunset this policy. This policy has been superseded by more recent policy (H-185.931, Workforce and Coverage for Pain Management; D-120.932, Inappropriate Use of CDC Guidelines for Prescribing Opioids).
H-120.948	Positive Verification of Contact Lens Prescriptions	Our AMA will support positive prescription verification for contact lenses and recommend that the federal government monitor the effects of the Fairness to Contact Lens Consumers Act (FCLCA) on the accuracy of prescriptions. (Res. 225, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-160.907	Hospital Inpatient Admission Order and Certification	Our AMA: (1) supports the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital as a condition for payment for inpatient services; and (2) believes that upon admission of any patient to a hospital for inpatient services, the admitting/attending physician should have access to appropriate information--for example the Geometric Mean Length of Stay (GMLOS)--to help the physician plan appropriately for the services that will be required to care for that particular patient~~; and (3) will inform the Centers for Medicare & Medicaid Services as soon as possible of the AMA's policy calling for the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital, and take appropriate action to enact this policy~~. (Res. 227, I-13; BOT action in response to referred for decision Res. 227, I-13; Reaffirmation A-14)	Retain this policy in part. Delete clause (3). Our AMA communicated to the Centers for Medicare & Medicaid Services the AMA's policy calling for the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital.
H-175.984	Health Care Fraud and Abuse Update	AMA policy is that: (1) our AMA leadership intensify efforts to urge federal policy makers to apply traditional definitions of fraud and abuse which focus on intentional acts of misconduct and activities inconsistent with accepted medical practice;	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(2) our AMA continue to work with federal law enforcement officials to improve the ability to root out intentional schemes to defraud public programs; (3) our AMA work with federal policymakers to balance payment integrity objectives with reasonable documentation and other administrative requirements; (4) our AMA develop model compliance plans and educational materials to assist physicians in conforming to the latest laws and regulations; and (5) our AMA continue to work in a coalition of other health care organizations to lobby for restrictions on the use of the False Claims Act. (BOT Rep. 25, I-97; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed in lieu of Res. 223, A-14)	
H-185.949	Centers for Medicare and Medicaid Services Policy on Hospital Acquired Conditions - Present on Admission	1. Our AMA will: (a) continue its strong opposition to non-payment for conditions outlined in the Hospital Acquired Condition - - Present on Admission (HAC-POA) policy that are not reasonably preventable through the application of evidence-based guidelines developed by appropriate medical specialty organizations based on non-biased, well-designed, prospective, randomized studies; (b) ask CMS or other appropriate bodies to monitor and evaluate practice changes made as a result of HAC-POA law, and associated outcomes, and report back on best practices; (c) educate physicians about the HAC-POA law and its implications for patient care, coding requirements and payment; (d) continue its education and advocacy of CMS, Members of Congress and the public about the unintended consequences of non-payment for hospital acquired conditions that may not in fact be preventable, and that adversely affect access to and quality of care; (e) oppose the use of payment and coverage decisions of governmental and commercial health insurance entities as determinative of the standard of care for medical practice and advocate that payment decisions by any third party payer not be considered in determining standards of care for medical practice; and (f) continue to study the effect of HAC-POA penalty programs on professional liability; potential institutional demands to control or micro-manage doctors' professional decision-making; and efforts to develop evidence-based information about which events may	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		be truly preventable as opposed to those whose frequency can be reduced by appropriate intervention. 2. Our AMA will: (a) continue its efforts to advocate against expansion of the Hospital Acquired Conditions - Present on Admission policy to physicians; (b) communicate to the Administration how burdensome the HAC-POA policy is for physicians and the Medicare program; (c) work with federal agencies to further monitor the HAC-POA program evaluation, and offer constructive input on its content and design; and (d) maintain efforts with our hospital association colleagues, such as the American Hospital Association, to monitor HAC-POA policy and its impact. (BOT Rep. 17, A-08; Appended: BOT Rep. 2, I-10; Modified: CCB/CLRPD Rep. 2, A-14)	
H-185.951	Home Anti-Coagulation Monitoring	1. Our AMA encourages all third party payers to extend coverage and reimbursement for home monitors and supplies for home self-monitoring of anti-coagulation for all medically appropriate conditions. 2. Our AMA (a) supports the appropriate use of home self-monitoring of oral anticoagulation therapy and (b) will continue to monitor safety and effectiveness data, in particular cost-effectiveness data, specific to the United States on home management of oral anticoagulation therapy. 3. Our AMA will request a change in Centers for Medicare & Medicaid Services' regulations to allow a nurse, under physician supervision, to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on ~~his/her~~their own to obtain and perform a protime/INR without restrictions. (Res. 825, I-05; Modified and Reaffirmed: CSAPH Rep. 9, A-07; Appended: Res. 709, A-14)	Retain – this policy remains relevant.
H-225.995	Duplication in Hospital Liability and Physicians' Professional Liability Insurance	Our AMA believes that (1) Each physician should be free to determine whether to carry liability coverage as well as the amount of such coverage. Likewise, it is the responsibility of the hospital governing board to determine the extent to which the hospital should protect its assets by purchasing liability insurance; and (2) Regardless of the type of insurance coverage or protection plan hospitals and physicians on the organized staff have, the AMA encourages medical	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		staffs and hospitals to work toward the establishment of effective risk management programs. (Res. 60, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Modified: Res. 813, I-02; Reaffirmation A-04; Modified: CMS Rep. 1, A-14)	
H-245.979	Opposition to Proposed Budget Cuts in WIC and Head Start	The AMA opposes reductions in funding for WIC and Head Start and other programs that significantly impact child and infant health and education. (Res. 246, I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-250.987	Duty-Free Medical Equipment and Supplies Donated to Foreign Countries	Our AMA will seek, through the federal government, a process to allow for duty-free donations of medical equipment and supplies, which are intended to reach medically-underserved areas and not be used for profit, to foreign countries. (Res. 229, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-275.918	Pediatric Medical Orders Between States	1. Our AMA supports legislation or regulation that allows physicians currently licensed and registered to practice medicine in any of the United States to duly execute conventional medical orders for their patients who are moving out of their state and into another state for use in any of the United States, for a transitional period of no more than sixty days. This would allow a child with special health care needs to attend early child care, daycare, nursery, preschool, and school safely in their new location while the family secures a new medical home, health insurance, and, when indicated, subspecialty care. 2. Our AMA will work with interested states and specialties on legislation or regulations to allow temporary honoring of medical orders by an out-of-state physician, as long as the physician is registered and licensed to practice medicine in the United States. (BOT Rep. 16, A-14)	Retain – this policy remains relevant.
H-330.974	Modification or Repeal of the Federal False Claims Act and Other Similar Statutes	It is the policy of the AMA to expend those resources necessary to monitor situations where physicians are under investigation, to provide financial and legal assistance where it is determined these are necessary, and to lobby for modification or repeal of the Federal False Claims Act and similar federal statutes. (Res. 152, A-90; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-01; Reaffirmed: BOT Rep. 22, A-11; Reaffirmed in lieu of Res. 223, A-14)	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-335.980	Payment For Copying Medical Records	It is the policy of the AMA to seek legislation under which Medicare will be required to reimburse physicians and hospitals for the reasonable cost of copying medical records which are required for the purpose of postpayment audit. A reasonable charge will be paid by the patient or requesting entity for each copy (in any form) of the medical record provided. (Res. 161, I-90; Appended by Res. 819, A-98; Reaffirmation A-08; Reaffirmed in lieu of Res. 710, A-14)	Sunset this policy. This matter is covered under Code of Medical Ethics 3.3.1, Management of Medical Records, which allows for physicians to charge a reasonable fee for the cost of transferring a record.
H-35.968	Averting a Collision Course Between New Federal Law and Existing State Scope of Practice Laws	~~1. Our AMA will: (A) work to repeal new Public Health Service Act Section 2706, so-called provider "Non-Discrimination in Health Care," as enacted in PPACA, through active direct and grassroots lobbying of and formal AMA written communications and/or comment letters to the Secretary of Health and Human Services and Congressional leaders and the chairs and ranking members of the House Ways and Means and Energy and Commerce and Senate Finance Committees; and (B) promptly initiate a specific lobbying effort and grassroots campaign to repeal the provider portion of the Patient Protection and Affordable Care Act's "Non-Discrimination in Health Care" language, including direct collaboration with other interested components of organized medicine. 2.~~ Our AMA ~~will: (A) create and actively pursue legislative and regulatory opportunities to~~ advocates for the repeal of the ~~so-called~~ "Non-discrimination in Health Care" clause in Public Health Service Act Section 2706, as enacted in the Patient Protection and Affordable Care Act~~; and (B) lead a specific lobbying effort and grassroots campaign in cooperation with members of the federation of medicine and other interested components of organized medicine to repeal the provider portion of PPACA's "Non-Discrimination in Health Care" language~~. (Res. 220, A-10; Appended: Res. 241, A-12; Appended: BOT Rep. 8, I-12; Modified: CCB/CLRPD Rep. 2, A-14)	Retain this policy in part. Delete part 1 and modify part 2. Our AMA has advocated for repeal of section 2706 of the Affordable Care Act and has successfully advocated to the Centers for Medicare & Medicaid Services to clarify, consistent with the statutory language in the ACA and with Medicare Advantage and Medicaid policies, that section 2706 does not go beyond existing Medicare or Medicaid rules regarding the scope of practice of particular types of non-physician practitioners, nor does it require health plans and issuers to contract with particular types of non-physician practitioners or cover all types of services.
H-350.962	Reauthorization of the Indian Health Care Improvement Act	Our AMA supports reauthorization of the Indian Health Care Improvement Act. (Res. 221, A-07; Modified: CCB/CLRPD Rep. 2, A-14)	Sunset this policy. The Indian Health Care Improvement Act (IHCIA) was made permanent in 2010 as part of the Patient Protection and Affordable Care Act.

Policy Number	Title	Text	Recommendation
H-355.975	Opposition to the National Practitioner Data Bank	1. Our AMA communicates to legislators the fundamental unfairness of the civil judicial system as it now exists, whereby a jury, rather than a forum of similarly educated peers, determines if a physician has violated the standards of care and such results are communicated to the National Practitioner Data Bank; and impresses on our national legislators that only when a physician has been disciplined by ~~his/her~~ their state licensing agency should ~~his/her~~ their name appear on the National Practitioner Data Bank. 2. Our AMA affirms its support for the Federation of State Medical Boards Action Data Bank and seeks to abolish the National Practitioner Data Bank. 3. Our AMA urges HHS to retain an independent consultant to (A) evaluate the utility and effectiveness of the National Practitioner Data Bank, (B) evaluate the confidentiality and security of the reporting, processing and distribution of Data Bank information, and (C) provide the findings and recommendations to the National Practitioner Data Bank Executive Committee and the General Accounting Office. 4. Our AMA will take appropriate steps to have Congress repeal Section 4752 (f) of OBRA 1990 requiring peer review organizations and private accreditation entities to report any negative action or finding to the Data Bank. 5. Our AMA seeks to amend the Health Care Quality Improvement Act of 1986 to allow a physician, at the time the physician notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report; 6. Our AMA opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on his or her behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers for purposes of credentialing or reimbursement. 7. Our AMA (A) urges HHS to work with the Federation of State Medical Boards to refine its National Practitioner Data Bank breakdown of drug violation reporting into several categories; (B) urges the HHS to analyze malpractice data gathered by the	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		Physician Insurance Association of America and recommend to Congress that a threshold of at least $30,000 for the reporting of malpractice payments be established as soon as possible; (C) will continue to work with HHS to allow physicians an expanded time period to verify the accuracy of information reported to the Data Bank prior to its release in response to queries; (D) will work with HHS and the Office of Management and Budget to reduce the amount of information required on the request for information disclosure form and to improve the design of the form to allow for more efficient processing of information; and (E) will continue to work with HHS to improve its mechanism to distribute revisions and clarifications of Data Bank policy and procedure. 8. Our AMA will review questions regarding reportability to the Data Bank and will provide periodic updates on this issue to the AMA House of Delegates. (CCB/CLRPD Rep. 3, A-14)	
H-365.980	OSHA Regulations Pertaining to Physicians' Offices and Hospitals	The AMA continues to review the data and rationale used to substantiate OSHA regulations pertaining to medical practice in physician offices and health care facilities. Where OSHA rules and regulations are found to be unnecessary or inappropriate, the AMA will work for their modification or repeal. (Sub. Res. 218, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-375.972	Lack of Federal Peer Review Confidentiality Protection	Our AMA will seek to vigorously pursue enactment of federal legislation to prohibit discovery of records, information, and documents obtained during the course of professional review proceedings. Our AMA will immediately work with the Administration and Congress to enact legislation that is consistent with Policy H-375.972. (Res. 221, I-96; Reaffirmed: BOT Rep. 13, I-00; Reaffirmation A-01; Reaffirmed: BOT Rep. 8, I-01; Reaffirmed: CMS Rep. 6, I-02; Appended: Res. 925, I-03; Reaffirmation A-05; Reaffirmed: BOT Rep. 13, I-11; Modified: CCB/CLRPD Rep. 2, A-14)	Sunset this policy. This policy is superseded by more recent AMA policy (D-375.999, Confidentiality of Physician Peer Review; H-375.962, Legal Protections for Peer Review).
H-40.967	Physician Participation in Department of Defense Reserve Components	1. Our AMA endorses voluntary physician participation in the military reserve components' medical programs as a means of actively aiding national defense while preserving the right of the individual	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		physician to practice ~~his/her~~ their profession without interruption in peace time. 2. Our AMA supports the U.S. Department of Defense by publicizing its needs for physicians in active duty military service and in the reserve components and guard, and encourages the active support and participation of physicians in active duty military service and in the reserves. 3. Our AMA will (a) continue to work with all appropriate parties in developing and proposing a multi-faceted approach toward rejuvenation and improvement in recruitment and retention in the military reserves; (b) work to assure that retired military medical personnel become eligible for reserve status; (c) support enactment of federal laws to assist physicians in the transition from medical practice to active military service; (d) promote use of existing laws for selective service and retirement credits as models for development of practical equitable criteria to be applied; and (e) support improvements in professional utilization of military medical personnel during both active duty periods and "weekend drill." 4. Our AMA supports the development of a statutory system of limitations on call-up, retention and recall of reservists in order to provide stability and predictability to reserve status and duty, with the basis for such a system to be defined statutorily using credits or "points" to prioritize options available to individual reservists as to call-up, retention, rotation and recall. (CCB/CLRPD Rep. 3, A-14)	
H-406.989	Work of the Task Force on the Release of Physician Data	1. Our AMA Council on Legislation will use the Release of Claims and Payment Data from Governmental Programs as a basis for draft model legislation. 2. Our AMA will create additional tools to assist physicians in dealing with the release of physician data. 3. Our AMA will continue to monitor the status of, and take appropriate action on, any legislative or regulatory opportunities regarding the appropriate release and use of physician data and its use in physician profiling programs. 4. Our AMA will monitor new and existing Web sites and programs that collect and use data on patient satisfaction and take appropriate action when safeguards are not in place to ensure the validity of the results. 5. Our AMA will continue and intensify its	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		extensive efforts to educate employers, healthcare coalitions and the public about the potential risks and liabilities of pay-for-performance and public reporting programs that are not consistent with AMA policies, principles, and guidelines. 6. Our AMA: A) opposes the public reporting of individual physician performance data collected by certification and licensure boards for purposes of MOC and MOL; and B) supports the principle that individual physician performance data collected by certification and licensure boards should only be used for the purposes of helping physicians to improve their practice and patient care, unless specifically approved by the physician. (BOT Rep. 18, A-09; Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed in lieu of Res. 808, I-10; Appended: Res. 327, A-11; Modified: CCB/CLRPD Rep. 2, A-14)	
H-415.998	Preferred Provider Organizations	The AMA: (1) opposes federal legislation that would preempt state regulation of PPOs; and (2) encourages state medical associations to support legislation that: (a) insures proper state regulation of PPOs, with particular attention to such practices as arbitrary determinations of medical necessity by carriers, "hold harmless" clauses, and predatory pricing concepts; and (b) requires independent, physician-directed peer review of the services provided by PPOs. (Sub. Res. 16, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-435.957	Uniform and Consistent Tort Reform	Our AMA will not pursue federal medical liability reform legislation that would divide or diminish the voice of the House of Medicine. (Sub. Res. 910, I-03; Reaffirmed in lieu of Res. 216, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-435.963	Professional Liability Claims Reporting	The AMA opposes the need for reporting on medical staff and other non-licensing board applications, including insurance company credentialing applications, (excepting professional liability insurance applications) any threatened, pending, or closed professional liability claims where the claim did not result in payment on behalf of that physician.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(Sub. Res. 818, A-95; Modified: BOT Rep. 18, A-03; Reaffirmed: Res. 806, I-03; Reaffirmation A-04; Reaffirmed: BOT Rep. 19, A-14)	
H-435.968	Enterprise Liability	The AMA: (1) affirms its position that effective medical liability reform based on California's MICRA model is integral to health system reform, and must be included in any comprehensive health system reform proposal that hopes to be effective in containing costs, providing access to health care services and promoting the quality and safety of health care services; (2) opposes any proposal that would mandate or impose enterprise liability concepts. Federal funding to evaluate the comparative advantages and disadvantages of enterprise liability may be best spent studying the operation, effect on liability costs and patient safety/injury prevention results of liability channeling systems that already exist and function as close analogs to the enterprise liability model (BOT Rep. I-93-53); and (3) supports strong patient safety initiatives and the investigation of alternative dispute resolution models, appropriate uses of practice parameters in medical liability litigation and other reform ideas that have the potential to decrease defensive medicine costs and more fairly and cost-effectively compensate persons injured in the course of receiving health care services. (BOT Rep. III, A-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmation A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-435.991	Professional Liability Countersuits	Our AMA supports the principle that the "special injury" element required to win a malicious prosecution countersuit in some jurisdictions should be eliminated. (Res. 44, I-84; Reaffirmed: Sunset Report, I-98; Reaffirmed: Sub. Res. 914, I-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-440.876	Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients	1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing	Retain this policy in part. Modify Part 2 by broadening the language and making it more consistent with Part 1.

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		health care. 2. Our AMA ~~will work with local and state medical societies to immediately, actively and publicly~~ opposes any legislative proposals that would criminalize the provision of health care to undocumented residents. (Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14)	
H-45.975	Proposed Change in Medical Requirements for 3rd Class Pilots' Licenses	Our AMA will: (1) oppose efforts to substitute the third class medical certificate with a driver's license; and (2) write a letter encouraging the Federal Aviation Administration to retain the third class medical certification process. (Res. 228, A-14)	Retain ~~Sunset this policy.~~ ~~Legislation was enacted in 2016 (Public Law 114-190, the FAA Extension, Safety, and Security Act of 2016) that statutorily allows pilots of small, non-commercial planes to forgo the medical certification process if the pilot and aircraft meet certain prescribed conditions under an FAA program called "BasicMed." A 2020 FAA study found no difference in accident risk between flights conducted by pilots operating under BasicMed and flights conducted by pilots holding third-class medical certificates.~~
H-478.987	Compliance with Meaningful Use Requirements as a Condition of Medical Licensure	1. Our AMA stands on record as opposing any requirement that medical licensure be conditioned upon compliance with "Meaningful Use" requirements. 2. Our AMA, working with state and specialty medical societies, will make efforts at all appropriate levels of government to secure the reversal of any requirements that medical licensure be conditioned upon compliance with meaningful use requirements. (Res. 232, A-14)	Sunset this policy. The Centers for Medicare & Medicaid Services renamed this EHR Incentive Program to the Medicare and Medicaid Promoting Interoperability Programs in April 2018. This policy has been superseded by more recent AMA policy (H-478.993, Implementing Electronic Medical Records).
H-478.991	Federal EMR and Electronic Prescribing Incentive Program	Our AMA: (1) will communicate to the federal government that the Electronic Medical Record (EMR) incentive program should be made compliant with AMA principles by removing penalties for non-compliance and by providing inflation-adjusted funds to cover all costs of implementation and maintenance of EMR systems; (2) supports the concept of electronic prescribing, as well as the offering	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		of financial and other incentives for its adoption, but strongly discourages a funding structure that financially penalizes physicians that have not adopted such technology; and (3) will work with the Centers for Medicaid & Medicare Services and the Department of Defense to oppose programs that unfairly penalize or create disincentives, including e-prescribing limitations for physicians who provide care to military patients, and replace them with meaningful percentage requirements of e-prescriptions or exemptions of military patients in the percentages, where paper prescriptions are required. (Sub. Res. 202, A-09; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 237, A-12; Reaffirmed in lieu of Res. 218, I-12; Reaffirmed in lieu of Res. 219, I-12; Reaffirmed in lieu of Res. 226, I-12; Reaffirmed in lieu of Res. 228, I-12; Reaffirmed in lieu of Res. 725, A-13; Appended: Res. 205, A-13; Reaffirmed in lieu of Res. 214, I-13; Reaffirmed in lieu of Res. 221, I-13; Reaffirmed in lieu of Res. 222, I-13; Reaffirmed in lieu of Res. 223, I-14)	
H-55.991	Use of Heroin in Terminally Ill Cancer Patients With Severe Chronic Pain	Our AMA remains opposed to legislation or any other action that would reschedule heroin from Schedule 1 to Schedule 2 of the Controlled Substances Act. (BOT Rep. TT, A-87; Reaffirmed: Sunset Report, I-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07; Modified: CCB/CLRPD Rep. 2, A-14)	Retain - this policy remains relevant.
H-60.940	Partner Co-Adoption	Our AMA will support legislative and other efforts to allow the adoption of a child by the non-married partner who functions as a second parent or co-parent to that child. (Res. 204, A-04) (Res. 204, A-04; Modified: CSAPH Rep. 1, A-14)	Retain – this policy remains relevant.
H-75.998	Opposition to HHS Regulations on Contraceptive Services for Minors	(1) Our AMA continues to oppose regulations that require parental notification when prescription contraceptives are provided to minors through federally funded programs, since they create a breach of confidentiality in the physician-patient relationship. (2) The Association encourages physicians to provide comparable services on a confidential basis where legally permissible.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(Sub. Res. 65, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: Res. 825, I-04; Reaffirmed: CMS Rep. 1, A-14)	
H-95.941	Restricting Prescriptions to Medicare Beneficiaries	1. Our AMA will work with the Centers for Medicare & Medicaid Services and state medical societies as needed to preserve access to care and eliminate the burden of provisions in the Patient Protection and Affordable Care Act that require physicians to enroll in Medicare, Medicaid and other governmentally sponsored health insurance programs as a condition of referring, ordering or prescribing for patients enrolled in these programs. 2. Our AMA supports federal legislation to eliminate the burden of provisions in the Patient Protection and Affordable Care Act that require physicians to enroll in Medicare, Medicaid and other governmentally sponsored health insurance programs as a condition of referring, ordering or prescribing for patients enrolled in these programs. (BOT Rep. 22, A-14)	Retain – this policy remains relevant.

10. AMERICAN MEDICAL ASSOCIATION CENTER FOR HEALTH EQUITY ANNUAL REPORT

Informational report; no reference committee hearing.

HOD ACTION: FILED

BACKGROUND

At the 2018 Annual Meeting, the House of Delegates adopted Policy D-180.981, directing our American Medical Association (AMA) to "develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities" and instructing the "Board to provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements." The HOD provided additional guidance via Policy H-180.944: "Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity." HOD policy was followed by creation of the AMA Center for Health Equity ("Center") in April 2019, the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 ("Plan") in May 2021, and the successor 2024-2025 Plan in June 2024. In 2022, updated Policy H-65.946 specified that this report will also include "updates on [the AMA's] comprehensive diversity and inclusion strategy."

DISCUSSION

Our AMA has committed itself to advancing health equity, advocating for racial and social justice, and embedding equity across the organization and beyond. In 2023, the Center continued to collect enterprise-wide equity related work and track progress toward the five strategic approaches detailed in the AMA's Plan. This report outlines the activities conducted by our AMA during calendar year 2023, divided into five strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3) Ensure Equity in Innovation; (4) Push Upstream;

and (5) Foster Truth, Reconciliation, and Racial Healing. Updates on diversity and inclusion strategy updates are included within the Embed Equity section.

Embed Equity

Ensuring a lasting commitment to health equity by our AMA involves embedding equity using anti-racism, structural competency, and trauma-informed lenses as a foundation for transforming the AMA's staff and broader culture, systems, policies, and practices, including training, tools, recruitment and retention, contracts, budgeting, communications, publishing, and regular assessment of organizational change. The following are some of the relevant accomplishments during 2023:

- At the 2023 Annual and Interim House of Delegates Meetings, there were various equity-focused reports, resolutions, and educational sessions. The adopted Council on Ethical & Judicial Affairs (CEJA) Report on "Responsibilities to Promote Equitable Care" will be added to the AMA *Code of Medical Ethics*. Other notable reports included: Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education, Decreasing Bias in Assessments of Medical Student Clinical Clerkship, Support Removal of BMI as a Standard Measure in Medicine, Leave Policies for Medical Students, Residents, Fellows, and Physicians, Financial Burdens and Exam Fees for International Medical Graduates, Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict, Federally Qualified Heath Centers and Rural Health Care, and Medicaid Unwinding Update. The Council on Science and Public Health (CSAPH) and National Academy of Medicine (NAM) co-hosted an educational session at the Interim Meeting on climate crisis and health care decarbonization. Health Equity Open Fora were held at the Annual Meeting, highlighting the Rise to Health Coalition, LGBTQ leadership, and truth and reconciliation, and the Interim Meeting, focused on the Health Equity in Organized Medicine survey report and the next Equity Strategic Plan. Each forum had over 300 individuals in attendance.
- AMA strives toward the enterprise's goal to raise its visibility in health equity and demonstrate its commitment to institutional and community partners. Website traffic related to health equity search was roughly 730,000 users. AMA published 127 news articles with health equity focus, representing 15 percent of its total production from the news team. Membership from users consuming health equity content increased 25 percent and referrals to health equity modules on Ed Hub from the AMA website increased 24 percent compared to the previous year. AMA update podcast downloads featuring health equity discussions increased 50 percent compared to the previous year, including more than 1,200 downloads. Approximately 15,000 learners completed AMA health equity courses for graduate and undergraduate medical education competency education programs (GCEP and UCEP). Major 2023 health equity announcements included the Rise to Health Coalition and the launch of the AMA's Truth, Reconciliation, Healing and Transformation (TRHT) taskforce initiative.
    - The Council of Science and Public Health (CSAPH) presented a report on equity in precision medicine, with a four-episode podcast series in development for release in 2024.
    - To support reimagining the future of health equity and racial justice in medical education and improving the diversity of the health workforce, as directed by the Council on Medical Education's Report 5 from June 2021, our AMA externally commissioned a diverse group of subject matter experts as editors who announced a call for authors, receiving over 150 submissions. Over 60 abstracts were published by the AMA in the compendium *MedEd's horizon: Just, merciful, diverse and equitable*. The final forward-looking study with recommendations for action will be a book with approximately 18 chapters entitled *Reimagining Medical Education,* to be published by Elsevier in 2024, and intended for medical school and health system leaders, medical educators in undergraduate and graduate medical education (UME and GME), policy makers, change agents, and advocates.
    - *AMA Journal of Ethics* published four health equity-centered issues in 2023: Segregation in Health Care, Patient-Centered Transgender Surgical Care, How We Over Rely on BMI and Palliative Psychiatry, with the first issue including an article led by AMA staff: Training to Build Antiracist, Equitable Health Care Systems.
    - To help embed equity within public health, the AMA published, in collaboration with the U.S. Centers for Disease Control and Prevention's (CDC) Project Firstline, 12 episodes of the Stories

of Care podcast about health care equity and infection control, including: Race, Research, and Health Care Associated Infections, Fighting Ableism: What Do You Need?, and Fighting Stigmas Associated With Infectious Diseases. Through October 2023, the Stories of Care podcast had a total of 1,311 downloads and 701 continuing medical education (CME) completions.

- The AMA continues to partner with the CDC and the Ad Council to encourage the public, with an emphasis on Black and Latinx/Hispanic audiences, to get vaccinated against influenza (flu). The donated media value for the most recent flu season was about $4.8 million. The public service announcement (as of October 2023) reached 53 percent among Black and 48 percent among Hispanic respondents. We held two media tours in 2023, both in English and Spanish, with spokespeople from AMA and CDC securing nearly 400 placements across TV, radio, and digital.
- The AMA published playbooks and other educational resources for physicians, practices, physician provider organizations, and health systems: as part of STEPS Forward, Wellness-Centered Leadership with a chapter on Racial and Health Equity; and with America's Health Insurance Plans (AHIP) and National Association of Accountable Care Organizations The Future of Sustainable Value-Based Payment: Voluntary Best Practices to Advance Data Sharing, incorporating the promotion of health equity as a key cross-cutting issue (particularly related to health-related social needs) and establishing a specific "best practice category" focused on health equity ("Improve Data Collection and Use to Advance Health Equity"). Additionally, AMA STEPS Forward published a toolkit, Collective Trauma: Respond Effectively as an Organization, and four podcasts focused on social determinants of health and racial and health equity.
- AMA STEPS Forward® hosted the first-ever free in-person Saving Time Boot Camp, intended for Federally Qualified Health Centers (FQHC) staff, offering evidence-based time management strategies to provide quality patient care.
- Private Practice Simple Solutions (PPSS) learning collaboratives were created in support of practices in communities that may lack financial resources to engage with consultants or other external partners.
- The AMA produced six Prioritizing Equity episodes, including: Examining Physician Gender Inequity in Medicine, The SCOTUS Affirmative Action ruling: The Cost to the Physician Workforce and Historically Marginalized Communities, and Advocating for Change in Native Health Policy.

- The AMA provided a detailed internal report to all staff on the first year of cross-enterprise and Business Unit (BU)-specific Equity Action Plans, including some 200 goals across BUs. Leadership approved moving forward with an Embedding Equity dashboard in 2024 starting with the 2020 Employee Equity and Engagement Survey data, moving forward with the next Employee Equity and Engagement Survey (slated to deploy in 2025), and implementing in 2024 the first enterprise-wide equity goals to be included in every BU's goals, focused on workforce and learning.
- The annual update to the Current Procedural Terminology (CPT) code set for 2024 included Spanish language consumer-friendly descriptors for the first time, which will help CPT users better engage and assist the Latinx community.
- For more than 50 years of the CPT Professional book being published and in circulation, every medical illustration that showed skin tone depicted a white person. In 2023, to address the past exclusion of images that represent the full diversity and identities of the people in our society, the book updated 19 illustrations, including changes to skin tone, facial features, hair, and sex. The 2024 edition updated and diversified 11 illustrations as well as reworked and made additional improvements to three illustrations from 2023. A large diverse group of internal and external reviewers provided feedback prior to publication. There is a three-year plan to update 75-100 more illustrations to depict authentic and diverse illustrations in the over 200,000 copies sold each year.

The AMA's employee life cycle and internal diversity, equity, and inclusion (DEI) framework help to operationalize DEI initiatives across the enterprise. Within the embedding equity strategic approach, updates on the AMA's diversity and inclusion strategy included a number of efforts and initiatives:

- Across AMA, hundreds of staff in 2023 engaged in training and educational opportunities with over 60 percent reporting an increase in knowledge, attitudes, skills, or behaviors. Training included the two-day Racial Equity Institute (REI) Phase 1, the Interaction Institute for Social Change (IISC) Facilitative Leadership for Social Change, the Equity & Results Antiracist Results-Based Accountability series, four new skills-based inclusion modules designed, developed, piloted, implemented and evaluated, and Business Unit-specific offerings led by their Health Equity Action Team.
- Individual Business Units have, with the leadership of their respective Health Equity Action Teams, pursued a variety of strategies to operationalize equity: had every team member commit to one of four committees and one goal from their Equity Action Plan, meeting at least monthly; designed and implemented internal monthly reporting to support transparency, dialogue, and decision-making; launched an internal monthly digest to educate colleagues; defined and shared a safe-space framework, rules, and expectations for town hall meetings and issues that arise; implemented community agreements across meetings and incorporated them into a project management playbook (with 79% finding the brave space community agreement beneficial); piloted Racial Healing Circles as a tool for team building across cultural divides; weaved meeting with the Health Equity Action Team about their Equity Action Plan and its progress into the new hire onboarding process; helped clients to consider embedding equity principles throughout projects (e.g., what language is being used, whether the team is diverse, is there a consideration of the project's impact on minoritized or marginalized communities, and other essential questions); and developed a process to ensure research proposals are evaluated for design bias and equity impact.
- The AMA is analyzing existing IT documentation in shared repositories for identification and removal of racially demeaning terms.
- Starting in 2023, several JAMA Network journals revamped and expanded their editorial fellowship programs to be part-time and fully remote to increase accessibility and inclusivity. The JAMA Network Equity Action Team (JNEAT) established guidelines for staff at every level to understand how to meet individual goals for improving Diversity, Equity, Inclusion, and Belonging – from supporting hiring managers in seeking a diverse candidate base for job openings to providing educational opportunities for staff. JAMA Network DEI editors continued quarterly discussions within their individual journals. The team will be publishing results of an inter-departmental survey of editors and editorial boards that highlight staff demographics, including self-identified gender, race, and ethnicity.
- The AMA made its offices more equitable, installing privacy strips in the restrooms, stocking menstrual supplies in all restrooms, facilitating hybrid meetings with necessary accommodations, and installing or ordering sit/stand desks and other ergonomic office equipment. The organization continues to work towards ensuring AMA offices are accessible for differently abled individuals.

Build Alliances and Share Power

Building strategic alliances and partnerships and sharing power with historically marginalized and minoritized physicians and other stakeholders is essential to advancing health equity. This work centers previously excluded people, expertise and knowledge, builds advocacy coalitions, participates in national networks, and establishes the foundation for true accountability and collaboration. The following are some of the relevant accomplishments during 2023:

- AMA's sponsorship plan reflected outreach to diverse audiences, including The National LGBTQ+ Journalists Association (NLGJA) and Asian American Journalists Association (AAJA) Journalists conferences.
- Three new health equity-oriented content partners were signed to AMA's Ed Hub: Docs with Disabilities, Radiology Health Equity Coalition (RHEC), and UCSF Center for Climate Health Equity. The AMA collaborated with HealthBegins to launch six modules of Upstream Training and Education.
- To further leverage existing resources and partnerships, AMA participated in four meetings with the Association of American Medical Colleges (AAMC) and the Accreditation Council for Graduation Medical Education (ACGME) about diversifying the physician workforce; attended three ACGME Diversity Officers Forums; delivered two webinars (Removing barriers and facilitating access: Supporting trainees with disabilities across the medical education continuum and Enhancing Diversity Among

Academic Physicians: Recruitment, Retention and Advancement), two presentations to Academic Physicians Section on equity, diversity and belonging focused on medical education and minoritized physician burnout and wellbeing, and three presentations on the implications of the Supreme Court (SCOTUS) decision of Students for Fair Admissions v. Harvard University and the University of North Carolina at Chapel Hill; and completed a review of configurative mapping on diversity in medical education.

- Continuing its work around physician workforce data, the AMA is collaborating with the AAMC and the ACGME to establish a common understanding for the categorization, reporting, and sharing of sociodemographic data, beginning with race and ethnicity. This collaborative completed a study and is finalizing a guide on the addition of the Middle Eastern North African (MENA) category, identifying best practices in aggregation and reporting. Categorization has been provided by the AMA to the American Board of Medical Specialties, Federation of State Medical Boards, Council for Affordable Quality Healthcare, Massachusetts Medical Society, and Workgroup for Electronic Data Interchange health equity work group. MedBiquitous, a standards development organization in the academic medicine space, has expressed interest in adopting the categorization being developed by the collaborative in lieu of creating their own.
- The AMA, alongside AHIP, the Alliance of Community Health Plans, the American Hospital Association, and Kaiser Permanente, launched the Common Health Coalition: Together for Public Health. The coalition is focused on translating the hard-won lessons and successes of the COVID-19 pandemic response into actionable strategies that will strengthen the partnership between our health care and public health systems. In 2024, the coalition will publish recommendations informed by technical advisory groups of subject matter experts and an advisory council of public health leaders, focused on four initial priority areas: spearheading greater coordination between the public health and health care systems; building shared, well-maintained emergency preparedness plans; establishing national standards for health care data that help identify health disparities; and modernizing infectious disease detection.
- AMA continues to work in partnership with the March of Dimes (MOD) and has contracted with MOD and Sinai Urban Health Institute to identify the impact of facility closures and loss of services on the South and West side of Chicago, with the goal of producing a final report in 2024. AMA aims to continue its engagement with and participation in the MOD workgroups (Dismantle Racism, Increasing Access to Care, and Engage Communities).
- AMA staff continue to volunteer locally and build meaningful relationships with community organizations. The Enterprise Social Responsibility (ESR) team has aligned with the health equity strategic framework by valuing and uplifting the variety and diversity of work and careers that address social determinants of health and contributes to wellness. ESR piloted a co-design process with three community partners to develop a signature service model to address emerging community needs while aligning with AMA's mission and equity goals. ESR identified and hosted about 35 community engagement opportunities to build healthy, thriving, equitable communities, including My Block, My Hood, My City; Gardeneers; and the Erie House.
- The second cohort of the Medical Justice in Advocacy Fellowship, an educational initiative in collaboration with Morehouse School of Medicine's Satcher Health Leadership Institute, culminated at the Interim meeting of the House of Delegates, where 11 physician leaders were celebrated and presented their health equity project concepts.
- The AMA launched its inaugural Summer Health Law Internship, an eight-week paid summer internship program for a third year or master's law student to learn more about health equity and health law; continued working with The Urban Alliance by hosting a summer internship program that exposes Chicago students to medical publication to provide career exposure; hired a summer intern from Chicago Public Schools in Finance; and partnered with University of Chicago's Youth Internship Program, hosting an onsite a panel discussion with 23 IT-interested high school students, and are exploring further IT mentoring opportunities.
- The AMA completed a total of 32 burnout assessments with FQHCs and/or community health centers, all organizations serving patients from predominantly historically marginalized communities. Twenty of the 32 assessments were conducted for the organizations in the Arizona Alliance, a consortium of FQHCs, as well as several virtual workshops and reporting sessions to provide insight into interventions to reduce

medical staff burnout. Several participating FQHCs were recognized through the AMA's Joy in Medicine™ Health System Recognition Program.

- Minority and/or woman owned businesses were identified and recommended for several projects, including one with an estimated value in excess of $250,000. Additionally, three West Side United (WSU) vendors were recommended for requests for proposals with more than $700,000 spent with Local Vendors reported in monthly WSU Anchor Partner meetings. The AMA released a DEI survey to professional services vendors with material levels of spending in 2023 to collect information about the vendors and their policies regarding marginalized populations and DEI.
- The AMA set a five-year goal to scale and improve programs to five million patients diagnosed with hypertension (HTN) to achieve a 10 mm Hg drop in systolic blood pressure (SBP) or reach BP goal, and one million patients identifying as Black, Latina/e/o/x/Hispanic, Asian, Indigenous, and other historically marginalized groups. As of the end of 2023, approximately 71,723 patients had been impacted, with 51percent from historically marginalized populations. This number includes patients from two large health care organizations located in the West Side of Chicago. Additionally, the AMA initiated projects to embed and advance equity within its AMA MAP HTN™ program to better understand the impact of the program on historically marginalized populations and identify opportunities to reduce inequities.

Push Upstream

Pushing upstream requires looking beyond cultural, behavioral, or genetic reasons to understand structural and social drivers of health and inequities, dismantle systems of oppression, and build health equity into health care and broader society. The following are some of the relevant accomplishments during 2023:

- AMA continues to embed equity in its state and federal advocacy work and continues to elevate this and other equity-related work accomplished among AMA members and Federation Societies. Equity-related policy priorities can be seen throughout the AMA's engagement with Congress, the Administration, state legislatures, and other policymakers, in the form of advocacy letters, presentations and testimony to state legislatures, national and medical organizations, and countless additional opportunities that engaged organized medicine and policymakers. In 2023, the AMA continued to actively voice support for:
    - International medical graduates (IMGs);
    - Deferred Action for Childhood Arrivals (DACA) recipients;
    - Migration and refugee population health and safety;
    - Nutrition programs expansion and culturally respectful dietary guidelines;
    - Medicaid coverage expansion;
    - Medicaid and Children's Health Insurance Program (CHIP) coverage extension;
    - Maternal and child health programs;
    - Protecting reproductive health;
    - Advancing data privacy principles and protecting the abuse/misuse of sensitive health data;
    - Enhanced revisions to the federal race and ethnicity data standards;
    - Mental health and substance use disorder parity laws;
    - Removing racial and gender inequities for treatment of substance use disorders;
    - Protections for physicians who seek care for wellness and burnout;
    - Evidence-based gender affirming care;
    - Prohibition of the so-called conversion therapy;
    - Fair student loan efforts;
    - Increased funding for graduate medical education;
    - Elimination of harmful race-based clinical algorithms;
    - Telehealth flexibilities in Medicare;
    - Reducing the prior authorization burden on patients; and
    - Addressing quality and administrative barriers in Medicare Advantage and other insurance plans.
- In late May, in partnership with Institute for Healthcare Improvement (IHI), and in collaboration with Race Forward, HealthBegins, Groundwater Institute, and a variety of other organizations, the AMA formally announced the launch of Rise to Health: A National Coalition for Equity in Health Care. The goal of the Rise to Health Coalition is to bring together individuals and organizations across five key audiences

(pillars) including: individual practitioners, health care organizations, professional societies, payers, and pharma, research, biotech organizations, to advance health equity by identifying shared solutions, common frameworks, and best practices for spread and scale.

- The AMA continues to publish highly engaging health equity content on the AMA Ed Hub site with 176 activities published in 2023. Uptake of equity content in 2023 far exceeded 2022, with 213,982 engagements (compared to 161,189) and 53,117 course completions (compared to 32,453). Four National Health Equity Grand Rounds sessions were held, which brought 10,189 registrations (8,254 new registrants) to the Ed Hub site: The History of Racism in US Health Care; Follow the Money; Breaking Down the Ivory Tower; and Creating Accountability Through Data. Each session was designed to maximize accessibility for viewers.
- The AMA is a founding member of The Gravity Project, a Health Level 7 Fast Healthcare Interoperability Resources Accelerator focusing on social determinants of health (SDOH) data interoperability. The AMA contributes funding and staff time, for leadership and co-development of the SDOH terminology and data exchange standards. The newly released White House "US Playbook to Address Social Determinants of Health" for federal initiatives recognized the Gravity Project throughout the document. The AMA provided education to physicians on the utility of CPT codes to document and provide services based upon identified SDOH.

Ensure Equity in Innovation

The AMA is committed to ensuring equitable health innovation by embedding equity in innovation, centering historically marginalized and minoritized people and communities in development and investment, and collaborating across sectors. The following are some of the relevant accomplishments during 2023:

- The AMA continues to strive toward the adoption, optimization, and sustainability of responsible, impact and equitable digitally enabled innovations. This includes highlighting organizations that are championing and implementing health equity on the Physician Innovation Network (PIN) and providing a place for the Principles of Equitable Innovation to engage in important conversations through PIN. The AMA connected stakeholders and fostered collaboration to improve the development, evidence base, and quality of digital health solutions.
- The AMA's In Full Health initiative, in collaboration with The New Voices Foundation, provided five microgrants to Black healthcare/health tech entrepreneurs to attend The New Voices Foundation Health Innovator Hub at ESSENCE Festival 2023. The Black health innovators created solutions through tech, community partnerships, and medicine – building businesses that meet critical needs in the Black community and advance health equity. The healthcare/health tech entrepreneurs exhibit at the Innovator Hub at the ESSENCE Festival, which is visited by over 500,000 people each year.
- At the May CPT Editorial Panel Meeting, they approved adding eight questions to the CPT Code Change Application to help the Panel make informed decisions about AI CPT applications and apply the AI Taxonomy (Appendix S in the CPT Code Set) consistently. One question asks the applicant to explain how bias factors into the algorithm data**.**

Foster Truth, Racial Healing, Reconciliation, and Transformation

The AMA recognizes the importance of acknowledging and rectifying past injustices in advancing health equity for the health and well-being of both physicians and patients. Truth, racial healing, reconciliation, and transformation is a process and an outcome, documenting past harms, amplifying and integrating narratives previously made invisible, and creating collaborative spaces, pathways, and plans. The following are some of the relevant accomplishments during 2023:

- The AMA launched the Truth, Reconciliation, Healing and Transformation (TRHT) Taskforce, comprised of 19 people: AMA Board of Trustees liaisons, members of the AMA House of Delegates, physicians from historically marginalized communities, and external subject-matter experts from key fields such as medical history and education, policy, ethics, philanthropy, and economics. Facilitated dialogues took place in New Mexico and on Chicago's West Side (at the Hatchery), with educational sessions at the 2023 Annual and

Interim Meetings of House of Delegates (HOD). The Hatchery and HOD sessions are being made available on Ed Hub in 2024.

Challenges and Opportunities

Commonly noted challenges to advancing health equity, in order of most frequently cited to least, include: 1) limited staff time and capacity for content engagement and external collaborations, 2) competing operational and scheduling priorities, 3) budgetary limitations for sustainability and scaling up, 4) lack of guidance and standardization across enterprise, and 5) uncertainty around implementation and evaluation of processes and projects. Additional progress has been made this year to promote diversity within the AMA, and continuation and scaling of these efforts are vital to advancement of equitable work and workplace.

Many of AMA's BUs reported exploring initiatives to foster space and engagement around diversity, inclusivity, transparency, and accountability among their unit. Other BUs reported relying on their Health Equity Action Team ("HEAT") staff leaders to lead and advance their respective unit's equity efforts, and while these leaders' expertise have made great strides toward spearheading initiatives and setting structures for equitable work, staff are faced with limited time, capacity, resources on top of competing priorities with tight deadlines. Some BUs have identified these issues, and a few have created opportunities for cross unit engagements to foster collaboration and reignite responsibility toward AMA's equity goals. As an organization, there is a keen interest in solidifying an enterprise-wide equitable workplace foundation and investing efforts toward strategic operationalizing of AMA's equity goals.

CONCLUSION

The highlighted accomplishments in this report capture only a fraction of the work accomplished and lessons learned within 2023. AMA staff have devoted countless hours to not only learning how they can work together to advance health equity but also to applying what they have learned within and outside the organization. AMA continues to push forward in its quest to advance health equity and embed racial and social justice, making significant progress towards fulfilling its commitments outlined in its 2021-2023 Strategic Plan.

11. SAFE AND EFFECTIVE OVERDOSE REVERSAL MEDICATIONS IN EDUCATIONAL SETTINGS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies H-95.908 and H-95.932

INTRODUCTION

At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 217 entitled, "Increase Access to Safe and Effective Overdose Reversal Medications in Educational Settings," was adopted. This resolution called on the AMA to:

- Encourage states, communities, and educational settings, to adopt legislative and regulatory policies that allow schools to make safe and effective overdose reversal medications naloxone readily accessible to staff and teachers to prevent opioid overdose deaths in educational settings;
- Encourage states, communities, and educational settings to remove barriers to students carrying safe and effective overdose reversal medications; and
- Study and report back on issues regarding student access to safe and effective overdose reversal medications.

The HOD adopted the resolution, which has been codified at Policy H-95.908, "Increase Access to Safe and Effective Overdose Reversal Medications in Educational Settings." In response to the third resolve of the HOD action, this report provides background information, a discussion on naloxone access in schools and other educational settings, relevant AMA advocacy initiatives, and other updates.

BACKGROUND

More than 2,200 adolescents (ages 10-19) died of a drug-related overdose between July 2019-December 2021, with nearly 84 percent of these deaths involving illicitly manufactured fentanyl. An opioid of any type was involved in more than 91 percent of deaths, according to the Centers for Disease Control and Prevention (CDC).[10] Naloxone was administered only 30 percent of the time, according to the CDC.[11] Unintentional drug overdose deaths among young people (ages 15-19) continued to remain high in 2022, according to the National Institute on Drug Abuse (NIDA).[12] Two-thirds of those who died did not have any history of prior opioid use.[13]

Naloxone was created in the 1960s and subsequently began being used in emergency departments and other hospital settings.[14] Naloxone distribution in the community became more prevalent in the 1990s through harm reduction organizations.[15] Naloxone is most commonly administered via intramuscular injection or intranasal spray, and user preference may vary depending on familiarity with a product and how to use it.[16] With respect to availability in schools and other educational settings, the nasal spray formulation is most commonly cited in school educational resources and guidelines. It is important to emphasize, however, that the AMA does not endorse any specific brand or generic formulation of naloxone or other U.S. Food and Drug Administration (FDA)-approved opioid overdose reversal agents. While it is beyond the scope of this report to review the several decades of life-saving benefits of naloxone, it is notable that AMA policy supports continued development of and access to additional medications to reverse opioid-related overdoses.

Access to naloxone in the community has increased considerably in the past decade. From 2012-2017, naloxone prescriptions dispensed in the United States grew from 1,061 prescriptions to nearly 270,000 prescriptions.[17] Naloxone prescriptions dispensed increased to nearly 1.7 million prescriptions in 2022. Based on our strong policy, the AMA continues to urge all physicians to prescribe naloxone or other overdose reversal medications to patients at risk of overdose—and to friends and family of those who might be in a position to save a life from overdose. The AMA also continues to encourage physicians and physician offices to educate patients about the availability of naloxone and other overdose reversal agents available over the counter, from pharmacists via a standing order, or reversal agents that may be available through public health agencies. The National Association of Counties details multiple strategies and examples to increase state- and community-level distribution of naloxone.[18]

In addition to physicians' increasing efforts in prescribing naloxone, the AMA also recognizes the longstanding role that harm reduction organizations have played in saving lives from overdose. Harm reduction and other community-based organizations distributed more than 3.7 million doses of naloxone between 2017–2020.[19] From August 2021 to July 2023, national harm reduction organization, Remedy Alliance For The People, sent 1,639,542 doses of generic injectable naloxone to 196 harm reduction projects in 44 US states, DC, and Puerto Rico, of which 206,371 doses were provided at no-cost to 138 under-resourced harm reduction projects.[20] Naloxone has saved hundreds of thousands of lives in the United States, and the Board of Trustees continues to strongly support all efforts to increase access to naloxone and other opioid overdose reversal agents.

DISCUSSION

Increasing access to naloxone was one of the first recommendations of the AMA Substance Use and Pain Care Task Force (Task Force),[21] which was first convened in 2014 and remains a vital part of ensuring that organized medicine communicates emerging issues and policies to improve outcomes and save lives. The Task Force's work, including providing input on and development of AMA model state legislation[22] to increase access to naloxone, has been part of every state now having broad naloxone access laws.[23]

AMA model legislation also includes broad authority and immunities for high schools, universities, and other educational settings to possess, distribute and administer naloxone to teachers, staff, and students. As a result of AMA and other organizations' advocacy, approximately 30 states authorize educational settings to administer naloxone, and it varies by state regarding whether that includes elementary schools, high schools, or schools of higher education.[24]

Multiple school districts and universities already provide naloxone and overdose prevention and education opportunities. While the total number continues to grow, representative examples can be found in Southwest Virginia, where nearly all schools carry naloxone,[25] and the state itself has amended its laws to authorize the ability for schools and school employees to carry, administer, and distribute naloxone.[26] All schools in the Miami-Dade public school system carry naloxone, although it is most commonly held by school public safety officials.[27] One

student remarked that she carries naloxone in her purse because, "Our friends do not know that those pills are more than likely to be fake [or] have enough fentanyl in it to kill you. And that is scary. I carry Narcan in my school bag. If I am going to a party, I will put it in my purse. It is just a layer of protection. You wear your seatbelt not because you are going get in a car accident. It is to keep yourself safe."

Additional examples of schools, universities and other educational settings carrying naloxone:

- University of Pennsylvania Perelman School of Medicine—medical students are taught how to recognize signs of overdose and administer naloxone on their first day of medical school.[28]
- University of Southern California—a group of pharmacy students found that once they started a naloxone education and distribution program, demand outpaced expectations.[29]
- Vanderbilt University—makes naloxone and other harm reduction supplies available for individuals as well as at public locations throughout campus.[30]
- Akron (Ohio) School District—voted to approve naloxone availability in schools in 2017.[31]
- Columbia (NY) University—students who carry naloxone have saved lives from overdose in the community[32] and in schools. Naloxone education events have occurred since 2018 and resulted in "more than 2,500 students, faculty, staff and community members on how to recognize an overdose and administer treatment."[33]
- University of South Carolina—naloxone is accessible at the university fitness center, school pharmacy and other locations.[34]
- Montana—authorizing naloxone distribution and use in schools has been one part of the state's naloxone efforts, which distributed more than 26,000 naloxone kits to first responders, law enforcement, schools, and others.[35]
- Texas—schools now are required to carry naloxone, which has been administered multiple times to save the life of a young person, according to news reports.[36]

This short list above of high schools, universities, and other settings is a very brief snapshot showcasing the fact that school districts recognize the value of having naloxone in educational settings. Given the rapid adoption of efforts to increase access to naloxone in school-based settings, data on the total number of educational settings with naloxone is not currently available. The Board of Trustees strongly encourages these trends to continue.

The Board of Trustees also wants to continue to dispel myths about naloxone. The Board is aware of ongoing myths that naloxone may increase risky drug use behaviors. Much like debunked and dangerous myths of how use of seatbelts encourages risky driving; that the presence of fire hydrants encourages arson; or "that HPV vaccination increases promiscuity or increases risky sexual behavior,"[37] the presence and availability of naloxone has consistently been found to not increase use of drugs or increase risk of overdose. For example, a 2023 study found that "Naloxone access laws and pharmacy naloxone distribution were more consistently associated with decreases rather than increases in lifetime heroin and [injection drug use] among adolescents."[38] The study authors make clear that "Our findings therefore do not support concerns that naloxone access promotes high-risk adolescent substance use behaviors." A smaller study of heroin users found "no evidence of compensatory drug use following naloxone/overdose training."[39] And a report from 2010 looking at multiple myths cited multiple studies disproving the link between naloxone availability and increased drug use.[40] The Board of Trustees further emphasizes that while the Board does not support illicit drug use, it unequivocally supports efforts to save lives from unintentional drug-related overdose, including dispelling myths and supporting widespread availability of naloxone and other opioid overdose reversal agents. The limitations of naloxone, however, should be recognized. NIDA advises that "People with physical dependence on opioids may have withdrawal symptoms within minutes after they are given naloxone. Withdrawal symptoms might include headaches, changes in blood pressure, rapid heart rate, sweating, nausea, vomiting, and tremors."[41] NIDA aptly points out, however, that "The risk of death for someone overdosing on opioids is worse than the risk of having a bad reaction to naloxone." The Board of Trustees agrees that death is a greater harm than withdrawal symptoms.

As noted in the 2023 AMA Overdose Epidemic Report, overdose and death related to illicitly manufactured fentanyl, methamphetamine and cocaine increase; and xylazine and other toxic synthetic adulterants present new challenges. Naloxone does not reverse an overdose related to methamphetamine, cocaine or other toxic substances. Naloxone also does not work to counteract overdose related to alcohol, benzodiazepines or xylazine, which may increase the sedative effects of opioids, making the antagonist effects of naloxone appear not as rapid or sustaining.[42] Polysubstance use, moreover, may be intentional or unintentional as illicit substances may contain

multiple toxic adulterants, including illicitly manufactured fentanyl.[43] The CDC, SAMHSA, NIDA and many other leading public health organizations, including the AMA, continue to counsel that in addition to immediately calling 911, it is still advised to administer naloxone because it is likely an opioid is present, and naloxone will not harm an individual. The Board of Trustees agrees and further points out that if an individual's overdose is related to multiple substances, administering naloxone could help reduce respiratory depression. Again, the benefits of naloxone outweigh the limitations.

The presence of fentanyl in the nation's illicit drug supply also has raised the question of whether additional doses of naloxone are necessary, greater dose strengths, or different opioid overdose reversal medication (OORM) work more effectively than another. According to SAMHSA, the evidence shows that:

- Giving more than one dose of naloxone and using higher dose products may not be necessary when responding to a known fentanyl overdose.
- An overdose may appear to need additional doses if other sedating drugs are present in the person's body, such as alcohol, benzodiazepines, or xylazine; however, rapidly giving more naloxone or using a stronger, more concentrated OORM will not necessarily speed up the reversal process.

In fact, SAMHSA reports that "Multiple studies have found that despite the presence of fentanyl, more doses were not associated with improved outcomes."[44] The Board of Trustees further emphasizes that there are multiple OORM that have been approved by the FDA. The AMA does not take a position on which OORM is more effective than another and—for the purposes of this report—encourages states, communities, and educational settings, to adopt legislative and regulatory policies that allow schools to make safe and effective overdose reversal medications such as naloxone readily accessible to staff and teachers to prevent opioid overdose deaths in educational settings. The Board of Trustees further encourages states, communities, and educational settings to remove barriers to students carrying safe and effective overdose reversal medications. The Board of Trustees wants to make clear that even when naloxone or other OORM saves a life from overdose, it is essential to seek immediate medical attention.

AMA POLICY

The two most relevant AMA policies covering the areas of this report are (1) "Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications"
(Policy H-95.932); and (2) "Prevention of Drug-Related Overdose" (Policy D-95.987).
Adoption of H-95.932 has helped the AMA to support a broad array of naloxone access initiatives for nearly a decade. As identified in H-95.932, these initiatives include:

> …legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone and other safe and effective overdose reversal medications, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone and other safe and effective overdose reversal medications delivery.

Moreover, in accordance with AMA policy, specifically "Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications" (Policy H-95.932), AMA advocacy has helped states enact broad liability protections "for physicians and other healthcare professionals and others who are authorized to prescribe, dispense and/or administer naloxone and other safe and effective overdose reversal medications pursuant to state law." As part of our advocacy to support broad access, in accordance with AMA policy entitled, "Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications" (Policy H-95.932), AMA continues "to encourage individuals who are authorized to administer naloxone and other safe and effective overdose reversal medications to receive appropriate education to enable them to do so effectively."

As noted briefly above, existing AMA policy entitled, "Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications" (Policy H-95.932), also allows for broad support for "the widespread implementation of easily accessible naloxone and other safe and effective overdose reversal medications rescue stations," as well as "access to and use of naloxone and other safe and effective overdose reversal medications in all public spaces regardless of whether the individual holds a prescription." This includes public schools and other educational settings.

Given the broad nature of our existing AMA policy, which is amply reflected in the positive developments to implement these policies throughout the United States, the Board of Trustees concludes that AMA policy is sufficient and that additional new policy is not necessary. This report also accomplishes the task set to the Board of Trustees to study and report back on issues regarding student access to safe and effective overdose reversal medications.

RECOMMENDATIONS

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

1. Existing American Medical Association (AMA) policy entitled, "Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications" (Policy H-95.932), be reaffirmed, and
2. The third resolve of Policy H-95.908, "Increase Access to Safe and Effective Overdose Reversal Medications in Educational Settings" be rescinded and that the policy be updated as noted.

> 1. Our AMA will encourage states, communities, and educational settings to adopt legislative and regulatory policies that allow schools to make safe and effective overdose reversal medications readily accessible to staff and teachers to prevent opioid overdose deaths in educational settings.
> 2. Our AMA will encourage states, communities, and educational settings to remove barriers to students carrying safe and effective overdose reversal medications.
> ~~3. Our AMA will study and report back on issues regarding student access to safe and effective overdose reversal medications.~~

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12. AMA EFFORTS ON MEDICARE PAYMENT REFORM

Reference committee hearing; see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy D-400.982

BACKGROUND

At the 2023 American Medical Association (AMA) Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy – D-385.945, "Advocacy and Action for a Sustainable Medical Care System" and amended Policy D-390.922, "Physician Payment Reform and Equity." Together, they declare Medicare physician payment reform as an urgent advocacy and legislative priority, call on the AMA to implement a comprehensive advocacy campaign, and for the Board of Trustees (the Board) to report back to the HOD at each Annual and Interim meeting highlighting the progress of our AMA in achieving Medicare payment reform until predictable, sustainable, fair physician payment is achieved. The Board has prepared the following report to provide an update on AMA activities for the year to date. (Note: This report was prepared in mid-March based on approval deadlines, so more recent developments may not be reflected in it.)

AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

The AMA's Medicare physician payment reform efforts were initiated early in 2022, following the development of a set of principles outlining the "Characteristics of a Rational Medicare Payment System" that was endorsed by 124 state medical associations and national medical specialty societies. These principles identified strategies and goals to: (1) ensure financial stability and predictability for physician practices; (2) promote value-based care; and (3) safeguard access to high quality care.

Subsequently, the AMA worked with Federation organizations to identify four general strategies to reform the Medicare payment system, including:

- Automatic annual payment updates based on the Medicare Economic Index (MEI);
- Updated policies governing when and how budget neutrality adjustments are made;
- Simplified and clinically relevant policies under the Merit-based Incentive Payment System (MIPS); and
- Greater opportunities for physician practices wanting to transition to advanced alternative payment models (APMs).

At the heart of the AMA's unwavering commitment to reforming the Medicare physician payment system lie four central pillars that underscore our strategic approach: legislative advocacy, regulatory advocacy, federation engagement, and grassroots, media, and outreach initiatives. Grounded in principles endorsed by a unified medical community, our legislative efforts drive the advancement of policies that foster payment stability and promote

value-based care. We actively champion reform through regulatory channels, tirelessly engaging with crucial agencies such as the Centers for Medicare & Medicaid Services (CMS) and the White House to address impending challenges and ensure fair payment policies. Our federation engagement fosters unity and consensus within the broader medical community, pooling resources and strategies to amplify our collective voice. Lastly, our continued grassroots, media, and outreach efforts bridge the gap between policymakers and the public, ensuring our mission is well-understood and supported from all quarters. Together, these pillars fortify our endeavors to achieve a more rational Medicare physician payment system that truly benefits all.

Legislative Advocacy

As a result of the continued advocacy efforts of the AMA and larger physician community and direct engagement with Congress, a collection of influential Dear Colleague letters and commonsense legislative reforms have been introduced that build upon "Characteristics of a Rational Medicare Physician Payment System" including:

H.R. 2474, the Strengthening Medicare for Patients and Providers Act, introduced on April 14, 2023 by Reps. Raul Ruiz, MD (D-Calif.), Larry Bucshon, MD (R-Ind.), Ami Bera, MD (D-Calif.) and Mariannette Miller-Meeks, MD (R-Iowa), would automatically update the Medicare physician payment schedule each year by Medicare's annual estimate of practice cost inflation, the MEI. H.R. 2474 currently has 126 bipartisan cosponsors.

On July 28, 2023, a bipartisan group of 101 U.S. House of Representatives members sent a letter to House leadership on the need to prioritize Medicare physician payment reform, following extensive grassroots support from the AMA and members of the Federation.

H.R. 6371, the Provider Reimbursement Stability Act, introduced on November 13, 2023 by Rep. Greg Murphy, MD (R-N.C.) and 14 original cosponsors, would reform the Medicare Physician Fee Schedule (MPFS) budget neutrality policies by: (1) requiring CMS to reconcile inaccurate utilization projections based on actual claims and prospectively revise the conversion factor (CF) accordingly; (2) raise the threshold that triggers a budget neutrality adjustment from $20 million to $53 million and increase it every five years by the cumulative increase in the MEI; (3) require the direct inputs for practice expense relative value unit (i.e., clinical wages, prices of medical supplies and prices of equipment) to be reviewed concurrently and no less often than every five years; and (4) require CMS to limit positive or negative budget neutrality adjustments to the CF to 2.5 percent each year. In November of 2023, the House Committee on Energy and Commerce advanced select provisions of H.R. 6371 to reform fee schedule budget neutrality policies.

H.R. 5013/S. 3503, the Value in Health Care (VALUE) Act, introduced on July 28, 2023 by Reps. Darin LaHood (R-Ill.) and Suzan DelBene (D-Wash.) in the House and Senators Whitehouse (D-R.I.) and Barrasso (R-Wyo.) in the Senate on December 13, 2023, would extend the 5 percent APM bonus and maintain the 50 percent revenue threshold for two years.

In November of 2023, the Senate Committee on Finance and the House Committee on Energy and Commerce advanced legislation to offset a portion (1.25 percent) of the 2024 CF cuts as well as to partially extend the APM bonus and maintain the current revenue threshold required for the bonuses. During these markups, members of both committees discussed the need for Medicare payment reform at length and secured pledges from the chairs to address the issue in earnest in 2024.

H.R. 6683, the Preserving Seniors' Access to Physicians Act, introduced on December 8, 2023 by Reps. Greg Murphy, MD (R-N.C.), Danny Davis (D-Ill.), Brad Wenstrup (R-Ohio), Michael Burgess, MD (R-Texas), Jimmy Panetta (D-Calif.) and Larry Bucshon, MD (R-Ind.), would provide full, short-term relief from the 3.37 percent cut imposed in 2024 due to the budget neutrality policies medicine is seeking to reform.

Nearly 200 bipartisan members of Congress cosigned a Dec. 13 letter led by Representatives Mariannette Miller-Meeks, MD (R-IA), Ami Bera, MD (D-CA), Larry Bucshon, MD (R-IN) and Kim Schrier, MD (D-WA) urging House and Senate leadership to expeditiously pass legislation to address looming 2024 Medicare payment cuts. Absent congressional intervention, Medicare physician payments will be reduced by 3.37 percent on Jan. 1, 2024, due to budget neutrality requirements within the Calendar Year 2024 MPFS Final Rule.

On Feb. 9, Senators Cortez Masto (D-NV), Blackburn (R-TN), Thune (R-SD), Barrasso (R-WY), Stabenow (D-MI) and Warner (D-VA) announced the formation of a bipartisan Medicare payment reform working group. The primary

goal of this working group is to explore the current problems with the MPFS, propose long-term solutions and make the necessary updates to the Medicare Access and Chip Reauthorization Act (MACRA), which sets physician payment policies in the Medicare program. The AMA will serve as a resource to the Senate working group.

On February 23, 2024, Senators John Boozman (R-AR) and Peter Welch (D-VT) along with 30 Senators colleagues sent a Dear Colleague letter calling on Senate leadership to advance a legislative solution to create stability in the Medicare program by addressing the 2024 cut to Medicare payments and ensure that physicians and clinicians have the necessary financial support to care for the nation's seniors.

The Consolidated Appropriations Act, 2024, H.R. 4366, which passed the House of Representatives and the Senate and was signed into law by President Biden on March 8, included provisions reducing by about half —1.68 percent —of the 3.37 percent across-the-board Medicare physician pay cut that took effect on January 1. The new pay rate took effect on March 9.

The legislation also included an extension of incentive payments for participation in eligible alternative payment models at a reduced rate of 1.88 percent and maintained the threshold requirements to qualify for such payments.

The AMA issued a statement expressing extreme disappointment that about half of the 2024 Medicare physician payment cuts required by the Medicare Fee Schedule will be allowed to continue. The AMA conveyed that failure to reverse these cuts will impact access to high quality care and physicians will find it more difficult to accept new Medicare patients.

The AMA will continue to work with Congress and the administration to build bipartisan support in Congress for a proposal that will put an end to the annual cycle of Medicare cuts that threaten seniors' access to care. Bipartisan support for the aforementioned legislative proposals continues to grow among rank-and-file Members of Congress. However, the need for further advocacy remains to push the relevant Committees and Congressional leadership to make Medicare physician payment reform a top priority.

The AMA is also in the process of finalizing legislative language that would: (1) simplify MIPS reporting and improve its clinical relevance; (2) reduce the potential severity of penalties (currently as much as -nine percent) for those scoring poorly under MIPS; (3) provide support to smaller practices that tend to score lower under the program; and (4) provide timely and meaningful performance feedback to physicians and expand the use of clinical data registries.

In addition to regular interactions with members of Congress and their staff by Advocacy staff, the AMA has sent a number of letters and statements to Capitol Hill, including the following:

- 1/2/23 - signed on a physician/allied health professions letter to Congressional committees requesting MACRA oversight hearings;
- 2/13/23 - signed on a coalition letter to committees on value-based care;
- 3/15/23 - a sign on letter developed by the AMA was sent to Congress regarding the Medicare Payment Advisory Committee (MedPAC) recommendation for an inflation-based update;
- 3/20/23 - an AMA statement was filed for the Senate Health, Education, Labor and Pensions Committee's health care workforce hearing, highlighting the impact of declining Medicare payments on the physician workforce;
- 4/19/23 - a sign on letter developed by the AMA was sent to the House expressing support for H.R. 2474;
- 5/3/23 - signed on a physician/allied health professions letter to Congress in support of H.R. 2474;
- 6/21/23 - the AMA submitted a letter for the record for a hearing by the House Energy & Commerce Oversight & Investigations Subcommittee on MACRA;
- 10/5/23 - the AMA responded to the Ways & Means Committee's Request for Information on ways to improve health care in rural and underserved areas;
- 10/19/23 - the AMA submitted a statement for the Record to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health as part of the hearing entitled "What's the Prognosis? Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors."
- 12/11/23 - the AMA wrote in strong support of H.R. 6683, the "Preserving Seniors' Access to Physicians Act," bipartisan legislation that blocks another round of damaging Medicare payment cuts;

- 1/17/24 - the AMA organized national medical organizations and state medical societies to write a letter strongly urging Congress to quickly pass legislation to reverse the 3.37 percent Medicare physician payment cuts that took effect on January 1, 2024.

Regulatory Advocacy

In anticipation of a new round of budget neutrality adjustments expected in 2024 due to implementation of the G2211 code for complex office visits, the AMA had a multitude of meetings with officials at CMS, the Department of Health and Human Services (HHS), and the White House to discuss options for reducing the severity of the adjustment—and to argue whether any adjustment is needed at all.

The proposed rule on the 2024 Medicare physician fee schedule that was released on July 13 revised the utilization estimate for G2211 that they used to calculate the budget neutrality adjustment from the 90 percent previously announced in 2021 to 38 percent, significantly reducing the impact on payments.

The AMA also secured another hardship exemption that physicians can claim under MIPS to avoid up to -nine percent in performance penalties in 2025.

On November 2, 2023, the CMS released the 2024 Medicare Physician Payment Schedule final rule reducing the 2024 Medicare CF by 3.37 percent. These cuts result from a -1.25 percent reduction in the temporary update to the CF under current law and a negative budget neutrality adjustment stemming in large part from the adoption of the new G2211 office visit add-on code. Unfortunately, these cuts coincide with ongoing growth in the cost to practice medicine as CMS projects a 4.6 percent Medicare Economic Index (MEI) increase for 2024.

Despite comments from the AMA and others that the G2211 add-on code is ambiguous and there is uncertainty about when to report it, CMS did not further reduce the utilization estimate or the associated budget neutrality impact. Specifically, CMS maintained its estimate from the proposed rule that the add-on code will be reported with 38 percent of office visits in 2024.

Notably, in response to organized medicine's advocacy, CMS maintained the performance threshold to avoid a penalty in the Merit-based Incentive Payment System (MIPS) at 75 points in 2024. As a result, 78 percent of eligible clinicians are expected to avoid a MIPS penalty in 2026, a significant improvement from CMS' earlier projection that just over half of eligible clinicians would avoid a penalty in the proposed rule.

Federation Engagement

A Medicare Reform Workgroup comprised of staff from national medical specialty societies and state medical associations was organized in 2022 and has continued to meet to develop consensus on medicine's reform proposals and advocacy strategies. The AMA also participates in a second coalition, organized by the American College of Radiology, which involves non-physician clinicians who bill under the Medicare fee schedule to expand our reach and minimize potential for divergent proposals and strategies.

Periodic telephone conference calls are held with staff for Federation organizations to keep them apprised of developments in Washington and to elicit their support for grassroots efforts.

Grassroots, Media, and Outreach

The AMA has maintained a continuous drumbeat of grassroots contacts through its Physicians Grassroots Network, Patients Advocacy Network, and its Very Influential Physicians program. Op eds have been placed in various publications from AMA leaders, as well as from "grasstops" contacts in local newspapers. Digital advertisements are running, targeted specifically to publications read on Capitol Hill, and media releases have been issued to highlight significant developments.

The AMA relaunched a dedicated Medicare payment reform web site, www.FixMedicareNow.org, which includes a range of AMA-developed advocacy resource material, updated payment graphics and a new "Medicare basics" series of papers describing in plain language specific challenges
presented by current Medicare payment policies and recommendations for reform.

2023 Fix Medicare Now Campaign Top Line Results

- 425,900+ FixMedicareNow.org Page views
- 173,60000+ FixMedicareNow.org Site Visitors
- 40,679,400+ Impressions
- 498,000+ Engagements
- 1,200+ #FixMedicareNow Social Media Mentions
- 450+ FixMedicareNow.org Advocacy Hub User Submissions
- 288,000+ Contacts to Congress

Message testing of arguments made in support and opposition to Medicare payment reform was completed in late 2023. Focus groups of U.S. voters were conducted in June, and a national poll was launched in late July. The results of this message testing have been utilized to refine language used in earned and paid media, as well as patient grassroots outreach.

CONCLUSION

As we forge ahead in continued partnership with the Federation to advance organized medicine's collective goals in our strategic mission to reshape the Medicare physician payment system, the AMA remains unwavering in its commitment to successfully pursuing the four pillars discussed in this report. Our steadfast dedication ensures that our members' voices are heard, and that we advocate for a system that is fair, sustainable, and reflective of the value physicians bring to patient care.

Facing a nearly 10 percent reduction in Medicare payments over the past four years, physicians are at a breaking point and are struggling to maintain access to care for the Medicare beneficiaries they treat. Rising practice costs, workforce shortages, and financial uncertainty coupled with the continued lack of positive Medicare payment updates is threatening the viability of physician practices. This is unsustainable and unacceptable.

While there has been some progress so far in 2024, significant advocacy work remains in the year ahead and beyond to achieve our vision of Medicare physician payment reform.

Please follow Advocacy Update, join the Physicians Grassroots Network, visit www.FixMedicareNow often for updated material and alerts, and follow other AMA communications vehicles to stay up to date and engaged on this topic.

RECOMMENDATIONS

1) Our AMA increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases.
2) Our AMA step up its public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3) Our AMA increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform.
4) Our AMA advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.

13. PROHIBITING COVENANTS NOT-TO-COMPETE

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy H-265.987

INTRODUCTION

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Resolution 237 entitled, "Prohibiting Covenants Not-to-Compete in Physician Contracts." Resolution 237 was introduced by California, American Academy of Family Physicians, American Association of Neurological Surgeons, American College of Surgeons, Congress of Neurological Surgeons, and The Society of Thoracic Surgeons. Resolution 237 stated the following:

> RESOLVED, That our American Medical Association support policies, regulations, and legislation that prohibits covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers (New HOD Policy); and be it further
>
> RESOLVED, That our AMA oppose the use of restrictive covenants not-to-compete as a contingency of employment for any physician-in-training, regardless of the ACGME accreditation status of the residency/fellowship training program (New HOD Policy); and be it further
>
> RESOLVED, That our AMA study and report back on current physician employment contract terms and trends with recommendations to address balancing legitimate business interests of physician employers while also protecting physician employment mobility and advancement, competition, and patient access to care - such recommendations to include the appropriate regulation or restriction of 1) Covenants not to compete in physician contracts with independent physician groups that include time, scope, and geographic restrictions; and 2) De facto non-compete restrictions that allow employers to recoup recruiting incentives upon contract termination. (Directive to Take Action)

As directed by the HOD, this report addresses only Resolve 3 of Resolution 237 (Resolve 3). As such, this report does not consider non-competes generally, nor does it adjust any AMA policy positions regarding the pros and cons of non-competes as they may exist between physician practices and physician employees.

In this report, "non-compete" is defined as "a contractual term between a physician employer, e.g., a hospital, and a physician employee that prohibits the employee from working within a certain geographic area and period of time after the physician's employment ends." For example, a restrictive covenant may prohibit the physician from practicing medicine within 10 miles of the location where he or she treated patients for two years after employment has ended.

BACKGROUND

Adoption of Resolution 237 made a significant change to the AMA's policy on non-compete clauses (a/k/a covenants not-to-compete or non-competes). Prior to Resolution 237, the AMA was primarily guided by *Ethical Opinion 11.2.3.1, Restrictive Covenants (Ethical Opinion 11.2.3.1),* which states that physicians should not enter into unreasonable non-competes.[1]

Pursuant to Resolution 237, AMA policy now requires the AMA to "support policies, regulations, and legislation that prohibits covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers." Resolution 237 does not supplant *Ethical Opinion 11.2.3.1*, which opposes the use of unreasonable physician non-competes. Thus, while Resolution 237 prohibits covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers, *Ethical Opinion 11.2.3.1* applies in

other contexts, and thus opposes the use of unreasonable non-competes between physician employers and physician employees.

Resolve 3 appears to recognize the negative impact that non-competes – even those used by physician employers – may have on physicians and patients. Specifically, Resolve 3 asks the AMA to make recommendations concerning the appropriate regulation or restriction of non-competes in physician contracts with independent physician groups that include time, scope, and geographic restrictions. What follows is a brief discussion regarding how non-competes may harm patients and physicians.

Non-competes Harm Patients

Enforcement of non-competes often harms patients by ending patient-physician relationships, e.g., if a non-compete forces a physician out of a community or otherwise makes the physician geographically inaccessible to patients. Patients may be particularly at risk when the non-compete severs long-standing patient-physician relationships where the physician has been taking care of patients with chronic illnesses. Similarly, a non-compete can thwart a patient's choice of physician.

Non-competes may hinder patients' ability to timely access care. For example, depending on the geographic area, there may be a few physicians, general practitioners, or specialists available to serve the patient population. Even if several physicians practice in the community, forcing a physician to leave the area may reduce the number of available physicians. Although a replacement physician may ultimately be recruited to the area, recruitment can be a lengthy process. In the meantime, the absence of the physician subject to the non-compete may frustrate timely patient access to physician services – assuming the community's remaining physicians have the capacity to take on new patients.

Non-competes may also harm patients by compromising physician autonomy. For example, most physician employment agreements allow the employer (and the physician) to end the agreement at any time, so long as the other party is given advance notice. (This is typically referred to as "without cause" termination). A physician who knows that an employer can end their employment at any time, which will in turn trigger a non-compete, may be very reluctant to engage in patient advocacy, and speak up about matters negatively affecting patient care, clinical decision-making, etc.

Non-competes Harm Physicians

Non-competes can also harm employed physicians by locking them into untenable working conditions or responsibilities that are detrimental to physicians' mental and/or physical health, thereby contributing to the physician burnout epidemic. A physician who is practicing medicine in demoralizing working conditions may feel an urgent need to find a job with a better working environment and where the employer listens to its physicians' concerns and fosters a workplace that is more conducive to the practice of medicine. If a competing employer in the community offers the physician such an opportunity, a non-compete would bar the physician from accepting the new position. The physician might solve this issue if he or she were willing to work for an employer outside the non-compete's geographic restrictions. Doing so, however, could not only force the physician to leave the area, but require the physician to uproot his or her family from a community where the family has established significant roots. As a practical matter, working outside of the non-compete's geographic restriction may then be completely out of the question. Thus, the physician will simply have no option but to stay in a demoralizing employment situation that continues to put the physician's mental and physical health at risk and increasingly subjects the physician to burnout.

Based on all of the above, we understand that employed physicians have a strong case for wanting the AMA to adopt policy calling for a complete ban on non-competes. However, while Resolve 3 requires the AMA to support a ban on non-competes in employment contracts with for-profit or non-profit hospitals, hospital systems, or staffing company employers, Resolve 3 does not call on the AMA to do the same with respect to non-competes between independent physician groups and their physicians. Rather, Resolve 3 asks the AMA to study and report back with recommendations to address balancing legitimate business interests (LBIs) of physician employers while also protecting physician employment mobility and advancement, competition, and patient access to care. Thus Resolve 3 appears to recognize that physician employers may feel the need to use reasonable non-competes to protect LBIs. The next paragraph discusses those interests.

Employer's Reasons for Requiring Restrictive Covenants

Physician employers may feel that reasonable non-competes are essential to protect LBIs, which may take several forms. For example, an independent physician group may train the physician, make referral sources and contacts available to the physician, give the physician access to patients and patient lists, market the physician in the community, and provide the physician with proprietary practice information to help the physician build up his or her practice. Physician employers may want to use non-competes to prohibit a physician from leaving and then opening up their own practice "down the hall," in the same building, or even across the street – after receiving the benefit of information, training, patient contacts, and other resources provided by the independent physician group. Non-competes may give the physician employer the freedom and security to invest significant resources in the employed physician's success, without the employer having to worry that the physician will later leave after the physician has developed a significant patient base, taking those patients with him or her.

DISCUSSION

There are two recent, major developments or trends relating to physician employment contract terms relating to the potential balancing of the physician employer and their employed physicians and patient access. These developments are: (1) the Federal Trade Commission's (FTC) proposed rule on non-competes and (2) the ongoing enactment of state legislation dealing with non-competes. Because the FTC's proposed rule bans physician non-competes, except with respect to 501(c)(3) organizations under the U.S. Internal Revenue Code (which includes at least some hospitals and health systems), the proposed rule is not a source of recommendations about how physician contracting, regulation, or restrictions to non-competes might modify non-competes themselves to achieve the balance described in Resolve 3. The proposed rule does not prohibit the use of reasonable confidentiality provisions to protect trade secrets and other confidential information or repayment agreements. These types of provisions might, if taken together, be a possible means of achieving the kind of balance described by Resolve 3.

Recommendations Concerning Possible Modifications to Traditional Non-competes

State legislatures continue to consider bills that address non-competes, and most states have enacted statutes that are applicable to non-competes between physician employers and physician employees. These laws, as well as court decisions, provide the basis of how non-competes between physician employers and physician employees might be regulated. In states where one or more of these laws do not apply, the following recommendations could also be considered in contract negotiations between physician employers and their employees as a means of trying to achieve the balance described in Resolve 3.

- **Bases of termination.** Rather than having the non-compete apply regardless of the reason for employment termination, the non-compete might be modified so that it is enforceable only if: (1) the physician terminated his or her employment without cause; (2) the physician's license to practice medicine, or prescribe or dispense controlled substances, is currently revoked; or (3) the physician is currently excluded from participating in Medicare, Medicaid, or any other governmental program providing compensation for services rendered to patients.

- **Duration.** A non-compete could be drafted so that it has a short duration. It is not unusual for physician non-competes to last two years. But, following the direction of several state laws, the duration could be reduced to one year, or even six months. For example, Connecticut limits the duration of a physician non-compete to no more than one year.[2] In a frequently cited Arizona Supreme Court case, the court affirmed a lower court's ruling that six months, rather than three years, was sufficient to protect the legitimate business interests of a physician practice with respect to competition from a formerly employed pulmonologist.[3]

- **Scope of services.** A non-compete should apply only to services that the employed physician provided to the physician employer, and not, for example, broadly restrict the physician from "practicing medicine." For example, a Louisiana court ruled that a non-compete was too broad because it prohibited the physician employee from engaging in the practice of medicine, rather than being limited to the pain management services that he provided.[4] On the other hand, the Illinois Supreme Court upheld a ruling holding that a non-compete prohibiting a physician from practicing medicine was not too broad.[5]

- **Working for competitors.** A non-compete could be structured so that it prohibits the departing physician from working for a competitor, rather than prohibiting the physician from working for any employer in the relevant geographic area.[6]

- **Tying the geographic scope of the non-compete to a single location**. A non-compete should be written so that it is tied to the specific location where the physician provided the majority of his or her services, sometimes referred to in state law as the "primary practice site." A non-compete should not include any geographic area where the physician employer has offices—since the employer may have several offices in a state or states.[7]

- **Reasonable buy-out provision.** A non-compete could be drafted so that the departing physician could buy his or her way out of the non-compete.[8] The amount of the buyout should be reasonable based on a predetermined formula to eliminate ambiguity concerning how the buyout amount will be calculated. However, in some cases, even if there is no dispute concerning the buyout's reasonableness, a departing physician may not be able to buy his or her way out of a non-compete because the amount of the buyout is more than the physician can pay.

- **Carve out for specific types of patients.** Some state statutes that do permit the use of non-competes allow the departing physician to continue to see patients with specific types of conditions. For example, the Texas statute permits the physician to still treat patients with an acute illness.[9] The Colorado statute may also serve as an example here. Although the Colorado law prohibits non-competes in physician employment agreements, it does permit punitive damages related to competition. However, punitive damages are not recoverable if the formerly employed physician is treating a patient with a rare disorder.[10]

Use of Contractual Provisions that are not Non-competes

There are other kinds of post-employment restrictions that may represent other ways of attempting to achieve the balance described in Resolve 3. A physician employer may, however, be concerned that these alternatives do not sufficiently protect its LBI. This section describes some of these other options, which may be used in combination with one another.

Trade Secrets

A contract clause obligating the departing physician not to disclose the employer's trade secrets is one way that the physician employer could protect its LBI. All states have laws protecting trade secrets and most states have adopted the Uniform Trade Secrets Act[11] (UTSA) in various forms. The UTSA defines "trade secret" as information, including a formula, pattern, compilation, program, device, method, technique, or process, that: (1) derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use and (2) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.

The UTSA includes a civil cause of action for trade secret misappropriation, which refers to disclosure or use of a trade secret by a former employee without express or implied consent. Moreover, the courts have held that trade secrets include patient lists, medical records, and superbills containing patient addresses, medical diagnoses and treatment codes, and patient insurance information.[12] AMA policy states, however, that billing records and associated medical records should not be treated as proprietary or as trade secrets.[13]

Confidentiality Clauses

Physician employers may also use confidentiality agreements to protect legitimate business interests. Confidential information includes, but is not limited to, trade secrets. Some state laws define "confidential information." For example, the Georgia non-compete statute defines "confidential information" in part to mean data and information:

> Relating to the business of the employer, regardless of whether the data or information constitutes a trade secret…disclosed to the employee, that has value to the employer; is not generally known to the employer's competitors; competitors of the employer; and includes trade secrets, methods of operation, names of customers, price lists, financial information and projections, route books, personnel data, and similar information…[14]

The employer should require that, upon termination of the physician's employment, that the departing physician promptly return any confidential information in the physician's possession or control to the physician employer, including but not limited to, information on electronic devices. Further, the physician employer should consider requiring the employee to agree to a provision prohibiting a physician from taking any property, patient lists, or records of the employer with him or her upon the termination or expiration of the employment agreement.[15]

Protecting Trade Secrets and Confidential Information Through Non-disclosure Agreements

A physician employer can take steps to protect both confidential and trade secrets information by requiring the employee to sign a non-disclosure agreement (NDA) that applies after the physician leaves the employer. An NDA needs to be (1) clear about the information that is protected and (2) specifically tailored to protect that information. Courts may refuse to enforce NDAs that are too broad, e.g., they apply to information that is not considered to be confidential.

In some circumstances an NDA may be so broad that it can function as a de facto non-compete. One example of an NDA functioning as a de facto non-compete is found in *Brown v. TGS Mgmt. Co., LLC*. In this case, "confidential information" included any information that was "usable in" or "relates to" the securities industry. A California court refused to enforce the NDA because it defined confidential information "so broadly as to prevent [the employee] from ever working again in securities trading" and thus, operated as a de facto non-compete. As a result, the court concluded that it could not be enforced under California law.[16]

While NDAs do not restrict the mobility of physician employees as much as non-competes, physician employers may be concerned that an NDA is not sufficient to protect its trade secrets and other confidential information. It may be challenging for the physician employer to detect a breach of an NDA in comparison with a non-compete. Further, there can be significant litigation concerning just what damage the breach has caused the employer. Issues with detection and establishing damage amounts are likely to make enforcement of NDAs more expensive than enforcement of non-competes. However, in lieu of having to prove damage amounts, the physician employer might, to the extent permitted by state law, be able to include in the employment contract a clause entitling the employer to liquidated damages if the physician breaches an NDA, although the amount of liquidated damages could itself be subject to litigation.

Non-solicitation Agreements

Most states that prohibit non-competes do not disallow the use of non-solicitation agreements (NSA). For example, the Minnesota non-compete statute does not prohibit an NDA, an agreement designed to protect trade secrets or confidential information, an NSA, or an agreement restricting the ability to use client or contact lists or solicit customers of the employer.[17] NSAs can apply to the physician employer's patients, employees, or both. An NSA should, however, entitle the physician to notify patients whom they have seen and who wish to continue care with them of their new location and be advised they may sign a records release to have their records transferred to their physician of choice.

As in the case of NDA, it is likely that an employer will find it more difficult, and thus more expensive, to detect the breach of an NSA and prove damages, as opposed to a non-compete. Proving a breach of an NSA may be particularly challenging because employees may want to work for, and patients may decide to continue their relationship with, the departing physician on their own initiative without any solicitation from the physician. Again, as in the case of breach of an NDA, the physician employer might, to the extent permitted by state law, include a liquidated damages provision in its employment agreement with the physician to remedy a breach of an NSA, which, as noted above, may also be the subject of litigation.

Repayment Agreements

Using a repayment agreement can be another way to attempt to achieve the balance described in Resolve 3. The main concern here most likely has to do with what costs are covered by the agreement. Fortunately, some state non-compete statutes address this issue. For example, the New Mexico non-compete law, which bans non-competes in physician employee contracts, states that during an initial employment period of less than three years, the physician employer can require the departing physician to repay all or a portion of: (1) a loan; (2) relocation expenses; (3) a signing bonus or other remuneration to induce the health care practitioner to relocate or establish a health care practice in a specified geographic area; or (4) recruiting, education, and training expenses.[18] The West Virginia non-compete statute, on the other hand, states that a physician employer may require an employed physician to

repay all or a portion of: (1) a loan; (2) location expenses; (3) a signing bonus; (4) remuneration to induce the physician to relocate or establish a physician practice in a specific geographic area; or (5) recruiting, education, and training expenses. (The West Virginia statute does permit the use of physician non-competes lasting no more than one year). Unlike the New Mexico statute, the repayment obligation appears to have no time limit.[19]

A physician employer must take care that the repayment agreement is fair and is not inflated by costs that do not reflect actual financial benefits conferred on the employed physician. Notably, the FTC's proposed non-compete rule states that a repayment agreement may function as a de facto non-compete if the repayment obligation is not reasonably related to the costs the employer incurred for training the worker.[20] The abuse of repayment agreements has come under fire from other quarters as a means of preventing employees from leaving their jobs through debt, and are being used as a work-around in states where non-competes are banned.[21] If a physician employer is considering how to structure a repayment agreement and what types of costs ought to be covered, the cost categories listed in the New Mexico and the West Virginia laws may be useful guides, keeping in mind that the cost amounts must also be reasonable.

AMA Educational and Advocacy Resources

The AMA has many educational and advocacy resources concerning non-competes. For example, the Advocacy Resource Center (ARC) has, pursuant to prior AMA policy, developed a comprehensive analysis of all state non-compete laws that apply to physicians entitled "Legislative Template: Covenants not-to-Compete in Physician Contracts." Those interested in this advocacy resource may obtain it by contacting the ARC at https://www.ama-assn.org/system/files/rc-legislative-template.pdf. The AMA Career Planning Resource webpage also has a wealth of information discussing physician employment issues, which includes information and tips regarding restrictive covenants. The AMA Career Planning Resource webpage may be accessed at https://www.ama-assn.org/residents-students/career-planning-resource/understanding-employment-contracts.

RELEVANT AMA POLICY

The following AMA policy is relevant to this Board Report:

- **Code of Medical Ethics 11.2.3.1 Restrictive Covenants**

  Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms.

  Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care.

  Physicians should not enter into covenants that:

  (a) Unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and

  (b) Do not make reasonable accommodation for patients' choice of physician.

  Physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program.

  AMA Principles of Medical Ethics: III, IV, VI, VII

- **Restrictive Covenants of Large Health Care Systems D-383.978**

  Our AMA, through its Organized Medical Staff Section, will educate medical students, physicians-in-training, and physicians entering into employment contracts with large health care system employers on the dangers of aggressive restrictive covenants, including but not limited to the impact on patient choice and access to care.

- **Restrictive Covenants in Physician Contracts H-383.987**

  Our AMA will provide guidance, consultation, and model legislation concerning the application of restrictive covenants to physicians upon request of state medical associations and national medical specialty societies.

- **Prohibiting Covenants Not-To-Compete in Physician Contracts H-265.988**

  (1) Our American Medical Association support policies, regulations, and legislation that prohibits covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers.

  (2) Our AMA will oppose the use of restrictive covenants not-to-compete as a contingency of employment for any physician-in-training, regardless of the ACGME accreditation status of the residency/fellowship training program.

  (3) Our AMA will study and report back on current physician employment contract terms and trends with recommendations to address balancing legitimate business interests of physician employers while also protecting physician employment mobility and advancement, competition, and patient access to care - such recommendations to include the appropriate regulation or restriction of a) Covenants not to compete in physician contracts with independent physician groups that include time, scope, and geographic restrictions; and b) De facto non-compete restrictions that allow employers to recoup recruiting incentives upon contract termination.

- **Covenants Not to Compete D-265.988**

  Our AMA will create a state restrictive covenant legislative template to assist state medical associations, national medical specialty societies and physician members as they navigate the intricacies of restrictive covenant policy at the state level.

RECOMMENDATIONS

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

1. That the AMA oppose all restrictive covenants between employers and physician employees and regularly update its state restrictive covenant legislative template.
2. That our AMA continue to assist interested state medical associations and specialty societies in developing strategies for physician employee retention.

REFERENCES

1 *See* https://policysearch.ama-assn.org/policyfinder/detail/%2211.2.3.1%20Restrictive%20Covenants%22?uri=%2FAMADoc%2FEthics.xml-E-11.2.3.1.xml
2 Conn. Gen. Stat. § 20-14p
3 *Valley Medical Specialists v. Farber*, 982 P.2d 1277, 1281 (Ariz. 1999)
4 *Paradigm Health Sys., L.L.C. v. Faust*, 218 So. 3d 1068, 1071 (La.App. 1 Cir. 2017)
5 *Mohanty v. St. John Heart Clinic, S.C.*, 225 Ill. 2d 52, 77 (2006)
6 *See e.g.,* NV Rev Stat § 613.195(6)(a) and (b)
7 *See e.g.,* Conn. Gen. Stat. section 20-14p and W. Va. Code § 47-11E-2
8 For statutory examples, see IN Code § 25-22.5-5.5 and TX Bus & Com Code § 15.50
9 Tex. Bus. & Com. Code § 15.50
10 C.R.S. 8-2-113
11 *See* https://www.uniformlaws.org/committees/community-home/librarydocuments?communitykey=3a2538fb-e030-4e2d-a9e2-90373dc05792&LibraryFolderKey=&DefaultView=&5a583082-7c67-452b-9777-e4bdf7e1c729=eyJsaWJyYXJ5ZW50cnkiOiI3NDkwMWU4OS0zZmFkLTRjOGItODk3Yi1jYWE2ZjA4N2U4ZWMifQ%3D%3D
12 *See e.g., Total Care Physicians, P.A. v. O'Hara*, 798 A.2d 1043, 1054 (Del. Super. Ct. 2001)

13 Physician Access to Their Medical and Billing Records D-315.971
14 O.C.G.A. § 13-8-51
15 *See e.g.,* W.Va. Code § 47-11E-3
16 *Brown v. TGS Mgmt. Co., LLC*, 57 Cal. App. 5th 303, 306, 319 (Cal. Ct. App. 2020); FTC Proposed Non-compete Rule, 88 F.R. 3482, 3509 (January 19, 2023) https://www.govinfo.gov/content/pkg/FR-2023-01-19/pdf/2023-00414.pdf
17 Minn. Stat. § 181.988
18 N.M. Stat. Ann. § 24-1I-3
19 W.Va. Code § 47-11E-3
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14. PHYSICIAN ASSISTANT AND NURSE PRACTITIONER MOVEMENT BETWEEN SPECIALTIES

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS 1 AND 2 REFERRED
RECOMMENDATIONS 3, 4, 5, 6 AND 7 ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy H-35.960

INTRODUCTION

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Resolution 239 entitled, "Physician Assistant and Nurse Practitioner Movement Between Specialties." This resolution asked the AMA to study the movement of nonphysician health care professionals between specialties.

Procedural History

Resolution 239 was introduced by the Arizona delegation and asked:

> That our American Medical Association Board of Trustees study and report back at the 2023 Interim meeting on the economic impact to primary care and other lower tier income medical specialties of specialty switching by Advanced Practice Providers (Directive to Take Action); and
>
> That our AMA Board of Trustees study and report back at the 2023 Interim meeting about possible options on how APP's can best be obligated to stay in a specialty tract that is tied to the specialty area of their supervising physician in much the same way their supervisory physicians are tied to their own specialty, with an intent for the study to look at how the house of medicine can create functional barriers that begin to make specialty switching by Advanced Practice Providers appropriately demanding. (Directive to Take Action)

Similar in intent, Resolution 262 was introduced by the Private Practice Physicians Section and asked:

> That our American Medical Association create a national task force that will make recommendations for the best process for advanced practice providers (APPs) to develop specialty designations or an associated apprenticeship process that is parallel to the specialties of the physicians that supervise them (Directive to Take Action);

> That our American Medical Association study and report back at Interim 2023 on the economic impact to medical practices of specialty switching by advanced practice providers (Directive to Take Action); and
>
> That our American Medical Association study and report back at the 2023 Interim Meeting about possible options on how advanced practice providers can best be obligated to stay in a specialty tract (Directive to Take Action).

Testimony on both of these Resolutions was limited. The Reference Committee heard that the AMA does not have the authority or purview over post-graduate clinical training requirements of nonphysicians and that the AMA has extensive resources detailing the education and training of nurse practitioners and physician assistants. However, the Reference Committee also heard testimony indicating that a growing number of nonphysicians are moving between specialties, and that this is a concern for physicians.

Seeking to meet the underlying concerns raised in Resolutions 239 and 262, the Reference Committee recommended that Resolution 239 be adopted with an amendment, and that the amended Resolution 239 be adopted in lieu of Resolution 262. The HOD agreed and ultimately adopted amended Resolution 239, which reads as follows:

> That our American Medical Association study the movement of nonphysician health care professionals such as physician assistants and nurse practitioners between specialties.

This Board of Trustees Report aims to address this directive. It examines the educational preparation of nurse practitioners and physician assistants and evaluates their ability to move between specialties.

BACKGROUND

The implications of specialty switching by nurse practitioners and physician assistants are best understood when one considers the underlying education, training, and certification of each profession.

Nurse Practitioner Education and Training

Nurse practitioners are one type of Advanced Practice Registered Nurse (APRN). While the focus of this board report is on nurse practitioner and physician assistant certification, the foundational documents for nurse practitioner education include APRNs in four types of "roles:" nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists (CRNAs). Each type of APRN has its own accreditation and certifying bodies. For example, CRNA programs are accredited by the Council on Accreditation of Nurse Anesthesia Education Programs (COA) and CRNAs can obtain certification from the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA). By contrast, the Commission on Collegiate Nursing Education (CCNE) and the Accreditation Commission for Education in Nursing (ACEN) both accredit nurse practitioner programs, and nurse practitioners may be certified by one of several different certifying bodies.

APRN education and training is based on foundational documents that were drafted and agreed to by leaders in the nursing profession:

- Two American Association of Colleges of Nursing (AACN) "Essentials" documents: *The Essentials of Master's Education in Nursing (2011)* and *The Essentials of Doctoral Education for Advanced Nursing Practice (2006)* (together, the *AACN Essentials*).
- The National Task Force on Quality Nurse Practitioner Education's *2016 Criteria for Evaluation of Nurse Practitioner Programs* (*NTF Standards*).
- The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education (APRN Consensus Model).

Taken together, these documents provide the framework for the curriculum and accreditation of nurse practitioner graduate education programs.

What is referred to as the "APRN Consensus Model" also provides a model for APRN regulation and certification. The APRN Consensus Model is the basis for the four distinct roles of APRNs and the six-population foci that are foundational to APRN education and training:

- Family/individual across the lifespan;
- Adult-gerontology;
- Pediatrics;
- Neonatal;
- Women's health/gender-related; and
- Psychiatric/mental health.

A nurse practitioner's specific educational experience will depend on their chosen population focus, and so will their certification. The APRN Consensus Model states that, "[e]ducation, certification, and licensure of an individual must be congruent in terms of role and population foci."[1] As such, distinct certifications—which are generally required for licensure—were created for each population focus, and in some cases for primary care as distinct from acute care. Each certification is aligned with a different educational track. In short, it is expected that a nurse practitioner's education and training will be based on the certification they plan to attain after graduation. Consequentially, nurse practitioner programs vary slightly based on the nurse practitioner's chosen population foci and the certification they plan to attain. Each certification has a somewhat different educational pathway, but all nurse practitioners must meet the same core academic requirements. The APRN Consensus Model provides the required "APRN core" courses included in the curriculum for all nurse practitioners (and all APRNs):

- Physiology/pathophysiology;
- Health assessment; and
- Pharmacology.[2]

Specialty training, by contrast, represents a "much more focused area of preparation and practice than does the APRN role/population focus level."[3]

Across all population foci, nurse practitioner clinical training requirements are largely not standardized, in sharp contrast to physician clerkships and residencies. Nurse practitioners only undergo 500-750 hours of clinical training. This results in evident experience gaps. For example, even though some of the nurse practitioner certifications broadly span patient populations, including across the lifespan from children to geriatric patients, studies on nurse practitioner education have documented that family nurse practitioners (FNPs) often receive minimal training across patient populations.

Notably, a study in the *Journal of Nursing Regulation* surveyed recent FNP graduates on how often they performed basic tasks like prescribing medications, obtaining a health history, ordering diagnostic tests, and developing differential diagnoses during their entire training.[4] The survey also examined these tasks across patient populations, providing a window into how the FNP education and training prepares students for practice. The results were shocking. For example, only
61.5 percent of FNPs reported they prescribed medications to an adult patient more than 10 times, 15 percent said they only prescribed medications to an adult patient one to two times.[5] The numbers were even lower for pediatric and geriatric patients. Only 44.6 percent and 56.3 percent of FNP students surveyed said they prescribed medications more than 10 times to a pediatric patient and geriatric patient respectively, with 5.5 percent and 4.0 percent of FNP students indicating they *never* prescribed medications to pediatric or geriatric patients respectively during their clinical training.[6] This study demonstrates the lack of standardization in nurse practitioner training programs. Yet, FNPs often practice across patient populations and increasingly in specialties outside primary care.

Nurse Practitioner Certification

For initial certification of nurse practitioners, two major certifying bodies exist: the American Academy of Nurse Practitioners Certification Board (AANPCB) and the American Nurses Credentialing Center (ANCC).[7] Each certifying body administers their own examination and offers their own certifications. Both AANPCB and ANCC require nurse practitioners to renew their certification every five years. Most states require certification for licensure as a nurse practitioner, and certification exams are generally aligned with population foci.

The AANPCB offers three initial certifications: Family Nurse Practitioner (FNP), Adult-Gerontology Primary Care Nurse Practitioner (A-GNP), and Psychiatric Mental Health Nurse Practitioner (PMHNP).[8] AANPCB's FNP examination is an online examination with 150 multiple choice questions, which must be completed in three-hours. In 2021 the pass rate was 84 percent. AANPCB has retired a couple of certifications, including the Adult Nurse Practitioner (retired in 2017) and Gerontology Nurse Practitioner (retired in 2012). Nurse practitioners who obtained these retired certifications can maintain the credential as long as they continue to renew their certification by completing the required clinical practice hours and continuing education.

ANCC offers four certifications for nurse practitioners: Family Nurse Practitioner (FNP-BC), Adult-Gerontology Primary Care Nurse Practitioner (AGPCNP-BC), Adult-Gerontology Acute Care Nurse Practitioner (AGACNP-BC), and Psychiatric Mental Health Nurse Practitioner (PMHNP-BC). ANCC's FNP-BC certifying examination includes 150-200 questions that vary in format from multiple choice, drop and drag, and multiple response. The average pass rate in 2021 was 87 percent. ANCC also offers certifications for registered nurses, as well as micro-credentials in certain sub-specialties. ANCC has also retired several certifications, including Acute Care Nurse Practitioner, Adult Nurse Practitioner, Adult-Psychiatric Mental Health Nurse Practitioner, Emergency Nurse Practitioner, Gerontological Nurse Practitioner, Pediatric Primary Care Nurse Practitioner, and School Nurse Practitioner. Like the retired certifications offered by AANPCB, nurse practitioners may renew these ANCC retired certifications to maintain their credential.[9]

	American Academy of Nurse Practitioners Certification Board (AANPCB)	American Nurses Credentialing Center (ANCC)
Current certifications	Family Nurse Practitioner (FNP) Adult-Gerontology Primary Care Nurse Practitioner (A-GNP) Psychiatric Mental Health Nurse Practitioner (PMHNP)	Family Nurse Practitioner (FNP-BC) Adult-Gerontology Primary Care Nurse Practitioner (AGPCNP-BC) Adult-Gerontology Acute Care Nurse Practitioner (AGACNP-BC) Psychiatric Mental Health Nurse Practitioner (PMHNP-BC)
Retired certifications	Adult NP (retired) Gerontology NP (retired)	Acute Care NP (retired) Adult NP (retired) Adult-Psychiatric Mental Health NP (retired) Emergency NP (retired) Gerontological NP (retired) Pediatric Primary Care NP (retired) School NP (retired)

While AANPCB and ANCC are the largest certifying bodies for nurse practitioners, other smaller certification bodies exist, including the American Association of Critical-Care Nurses (AACN), National Certification Corporation (NCC), Pediatric Certification Board (PNCB), Certification Board for Urological Nurses & Associates (CBUNA), and Hospice & Palliative Credentialing Center (HPCC).

Nurse Practitioner Specialties

Under the APRN Consensus Model, advanced practice registered nurses are licensed at the level of the population focus—not at the specialty level.[10] Advanced practice registered nurses cannot be licensed solely within a specialty area.[11] Regarding specialties, the APRN Consensus Model notes that specialties are optional but must be congruent with and build on the individual's established role and population foci.

Nurse practitioners may pursue optional certification in various specialties/subspecialties after initial certification in their role and population focus. An array of certifying boards issue "specialty" certifications for nurse practitioners—typically these certifications are based on hours of practice experience in a specialty and passage of an exam. Customarily, the certifying boards are specific to nursing and specific to a single specialty. For example, the Orthopaedic Nurses Certification Board certifies nurse practitioners in the orthopaedic specialty (ONP-C) and the Dermatology Nurses Association certifies dermatology nurse practitioners (DCNPs). However, AANPCB offers an Emergency Nurse Practitioner (ENP) certification for certified FNPs with specialty education and practice in emergency care.

Note that specialty certification is generally not required for practice within a given specialty—indeed, work within a specific specialty is required to earn specialty certification.

Nurse Practitioner Workforce

Nurse practitioners are not required to practice within the specialty in which they are certified, and so there is great misalignment between nurse practitioner certification and the setting or specialty in which they practice. The APRN Consensus Model attempts to align the nurse practitioner curriculum with the certification a nurse practitioner can attain after graduation, however, a nurse practitioner's certification is not always congruent with the specialty or setting in which the nurse practitioner practices during their career. Myriad data sources confirm this misalignment. For example, the American Association of Nurse Practitioners (AANP) claims that 88 percent of nurse practitioners are certified in primary care, but also reports that only 70.3 percent of nurse practitioners deliver primary care. The most recent Health Resources and Services Administration (HRSA) workforce data suggests a greater disparity, reflecting that only 24 percent of nurse practitioners deliver primary care.[12]

HRSA's findings are consistent with several state-level workforce studies, including the following:

- A study from the Oregon Center for Nursing examined the number of nurse practitioners practicing in primary compared to specialty care in Oregon. Looking at practice setting and area of practice, data from

the survey revealed that only one-third of nurse practitioners practice in primary care and about 22 percent provided a combination of primary and specialty care. Of those nurse practitioners providing both primary and specialty care, about 62 percent spent less than half of their time focusing on primary care.[13] The study found that the gap between nurse practitioners providing primary care versus specialty care is widening over time, with a greater number of nurse practitioners providing specialty care and fewer nurse practitioners providing primary care. It concluded that certification alone is not enough to determine one's area of practice.

- Adding to this body of evidence is *A Profile of New York State Nurse Practitioners, 2017*, a workforce report in which only about *one-third* of actively practicing nurse practitioners were considered primary care nurse practitioners based on their specialty certification and practice setting, even though a vast majority of nurse practitioners in the state report a primary care specialty certification. To indicate, 87 percent of nurse practitioners reported a certification in primary care (36.8 percent in family health, 23.2 percent in adult health, 8.1 percent in pediatrics). [14]
- A *2023 South Dakota Workforce Study* had similar findings.[15] Based on data gathered from nurse license renewal applications, including nurses who renewed their license, reactivated an inactive license, or reinstated a lapsed license, 80.9 percent indicated they were licensed and certified as family nurse practitioners yet only 24.9 percent identified "family health" as their primary area of specialty, 5.1 percent chose "primary care", and 6 percent chose adult health.[16] Other notable specialties selected include "other"
(11.6 percent), psychiatric/mental health/substance abuse (8.2 percent), acute/critical care (7.3 percent), cardiology (4.2 percent), and emergency/trauma (3.5 percent).[17]

Studies also elucidate lack of congruence between nurse practitioners' certification and their practice in acute care settings.[18] As noted earlier, some certifications distinguish between primary and acute care—and this distinction is ostensibly reflected in the nurse practitioner's educational track. Yet, many nurse practitioners are certified in primary care work in an acute care practice specialty or setting.

A study published in *Nursing Outlook* using data from HRSA's 2018 National Sample Survey of Registered Nurses found that among nurse practitioners working in acute care settings, only
44.5 percent held a certification in acute care, while 55.5 percent held only a primary care certification (13.7 percent held both acute care and primary care certifications). Notably, only about half of nurse practitioners working in acute care reported that they feel prepared to be an independent practitioner.[19]

Below are findings by clinical specialty area in which the respondents worked:

	Acute Care Certified (N = 8,256)	Primary Care Certified (N = 10,297)
Total	44.5%	55.5%
Clinical Specialty		
General medical surgical	27.5%	37.6%
Critical care	23.5%	25.3%
Chronic Care	30.0%	10.6%
Neurological	6.4%	7.0%
Oncology	5.0%	9.2%
Other	7.6%	10.3%

*from Nursing Outlook $p < .01$

These findings were consistent with other studies examining the misalignment between nurse practitioners' credentials and their practice setting. For example, using data from the AANP National Nurse Practitioner Sample Survey, researchers found that of the 366 nurse practitioners who responded they were a hospitalist caring for adult patients (i.e., in an acute care setting),
74.7 percent were certified in primary care—with a full 75 percent indicating "on-the-job training" as their qualification to be a nurse practitioner hospitalist.[20]

Similarly, while emergency departments are for acute-life or limb threatening emergencies and providing care to critically ill patients, most nurse practitioners working in emergency departments are certified as an FNP. In fact,

while there is a separate specialty certification for emergency nurse practitioners (ENPs), only FNPs are eligible for such certification—not acute care nurse practitioners, even though emergency departments are acute care settings. Moreover, 90 percent of nurse practitioners practicing in emergency departments do not have the ENP additional specialty certification.[21]

Altogether, education and certification are not determinative of where a nurse practitioner will practice—workforce studies show that nurse practitioners commonly practice in clinical settings or specialties that are misaligned with, their education, training, and credentials.

Specialty Switching by Nurse Practitioners

Nurse practitioners may switch specialties throughout their career with few limitations, with the primary limitation being that, per the APRN Consensus Model, a nurse practitioner's specialty must align with the population focus of the nurse practitioner's training, as well as their certification. For some nurse practitioners this provides broad latitude in mid-career changes. For example, FNPs are trained to provide primary care across the lifespan and so would qualify for a broad range of specialties. By contrast, an adult-gerontology primary care nurse practitioner (AG-PCNP) might be more limited. For example, an AG-PCNP would likely have to complete additional training to care for children, or to care for adult or geriatric patients outside primary care.[22]

Physician Assistant Education and Training

Physician assistant programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) and are two-to-three years in length. Physician assistant programs provide a generalist education rather than focus on a particular specialty.[23] Per the standards, program curriculum must include, "applied medical, behavioral and social sciences; patient assessment and clinical medicine; *supervised clinical practice*; and health policy and professional practice issues."[24] Upon completion of the program graduates are awarded a master's degree and become eligible to sit for the physician assistant certification examination.

Physician Assistant Certification

A single body certifies physician assistants: the National Commission on Certification of Physician Assistants (NCCPA). Certification is available to physician assistants who graduate from an ARC-PA accredited program and pass the Physician Assistant National Certifying Examination. Physician assistants are eligible to take the examination up to six-years after graduation and those who pass are awarded the PA-C credential. To maintain certification, physician assistants must complete a minimum number of hours of continuing medical education (CME) and pass the Physician Assistant National Recertifying Examination (PANRE) every 10 years. Most states require completion of a minimum number of hours of CME, current certification by NCCPA, or both as a condition of licensure or for licensure renewal.

The single certification for physician assistants is consistent with the approach for physician assistant education and training—to provide a generalist education without a focus on specialty. This is evident in both the didactic curriculum and clinical training of physician assistants. For example, the 2,000 hours of clinical practice required of physician assistants includes rotations in various specialties, including emergency medicine, obstetrics and gynecology, psychiatry, family medicine, and internal medicine. Standards also include requirements that these clinical rotations must include specific types of encounters. For example, physician assistant students must treat patients requiring chronic, acute, emergent, and preventive care and must also provide care in a variety of settings, including the emergency department, outpatient, and inpatient facilities. There is no path for specialized focus in the physician assistant educational program.

In addition to the PA-C certification, NCCPA also offers optional specialty Certificates of Added Qualification (CAQs) to physician assistants in 10 specialties, including:

- Cardiovascular & Thoracic Surgery;
- Dermatology;
- Emergency Medicine;
- Hospital Medicine;
- Nephrology;

- Obstetrics and Gynecology;
- Orthopaedic Surgery;
- Palliative Medicine and Hospice Care;
- Pediatrics; and
- Psychiatry.[25]

A physician assistant who has acquired a CAQ is considered "board certified." The specific requirements vary by specialty but generally require the following: (1) completion of specialty-specific CME, (2) attestation that the physician assistant has completed a certain number of hours of experience in the specialty, (3) attestation that the physician assistant has the knowledge and skills relevant to practice in the specialty, including the knowledge and skills to perform the procedures relevant to the specialty, and/or that the physician assistant understands how and when the knowledge and skills should be applied for appropriate patient management or how and when the procedures should be performed, and (4) achieve a passing score on a specialty examination (online or in person).

CAQs often rely heavily on attestations and may not actually require the physician assistant to complete relevant procedures. Consider as an example the requirements to attain a CAQ in emergency medicine:

- Self-attest to completing 75 credits of Category 1 CME focused on emergency medicine; 25 of which must be earned within two-years of the date of the application for the specialty examination and the remaining earned within six years before this date.
- Complete a comprehensive emergency medicine course that reflects the guidelines set forth in the most current version of Model of the Clinical Practice of Emergency Medicine, and complete the following courses:
    - Pediatric Advanced Life Support or Advanced Pediatric Life Support
    - Advanced Trauma Life Support
    - Airway course
- Self-attest to completing 3,000 hours of experience working as a physician assistant in emergency medicine within at least six-years.
- Obtain attestation from a physician, lead/senior physician assistant, or physician/physician assistant post graduate program director who works in emergency medicine and is familiar with the physician assistant's practice and experience. The attestation must affirm that the physician assistant, "*has performed* the procedures and patient management relevant to the practice setting and/or *understands* how and when the procedures *should* be performed…the PA may not have experience with each procedure, but he or she must be knowledgeable of the basics of the procedures, in what situation the procedures should be done, and the associated management of patients."[26]
- Pass an examination which consists of 120 multiple choice questions, which can be taken at a test center or online.

CAQs are wholly optional for physician assistants and are generally not required for physician assistants to practice. Indeed, before earning and in order to earn a CAQ in the first instance, a physician assistant must practice in a chosen specialty.

Physician Assistant Workforce

According to the NCCPA 2022 statistical profile of board-certified physician assistants, only 23.1 percent of physician assistants work in primary care, which includes "family medicine/general practice, internal medicine general, and pediatrics general." When asked to identify their primary area of practice, the most physician assistants reported working in the five specialties:

- Surgical subspecialties (18.6 percent);
- Family medicine/general practice (17.1 percent);
- Emergency medicine (11.2 percent);
- Other (10.6 percent; *note that the most frequent responses include: urgent care, interventional radiology, sleep medicine, aesthetics, trauma surgery, wound care, and transplant surgery); and
- Internal medicine subspecialties (9.9 percent).

Most physician assistants practice in hospital settings (41.7 percent) with office-based private practice a close second (37.1 percent). Urgent care (5.6 percent) and federal government facility/hospital/unit (4.7 percent) are a distant fourth and fifth.

While most physician assistants hold one clinical position (84.9 percent), 11.3 percent of physician assistants hold two or more clinical positions, with emergency medicine (25.6 percent) being the most common secondary specialty area of these physician assistants.

Specialty Switching by Physician Assistants

Since physician assistants are trained as "generalists," they face very few barriers to specialty switching. Indeed, more than half have changed specialties at least once during their career with over 20 percent indicating they have changed specialties two to three times.[27] This can be done without any additional education, formal training, or certification.

AMA POLICY

The AMA has extensive policy supporting physician-led team-based care, including policy on appropriate physician supervision of nurse practitioners and physician assistants:

- Policy H-160.949, "Practicing Medicine by Non-Physicians;"
- Policy H-160-906, "Models /Guidelines for Medical Health Care Teams;"
- Policy H-160.950, "Guidelines for Integrated Practice of Physician and Nurse Practitioner;"
- Policy H-360.987, "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice;"
- Policy H-35.989, "Physician Assistants;" and
- Policy D-35.985 "Support for Physician Led, Team Based Care."

The AMA also has policy directing our AMA to educate the public on the difference in the education and training of physicians and non-physicians. Specifically:

- Policy H-160.949, "Practicing Medicine by Non-Physicians;"
- Policy H-450.955, "Education of the General Public on the Role of Physician and Non-Physician Health Care Providers;" and
- Policy H-275.943, "Public Education about Physician Qualifications."

DISCUSSION

The nurse practitioner and physician assistant professions both began with an emphasis on providing primary care to patients to help address the primary care workforce shortages. Over time, however, both nurse practitioners and physician assistants are increasingly choosing to practice in specialties instead of primary care and may switch specialties multiple times during their career. The idea of specialty switching by nurse practitioners and physician assistants is not a new phenomenon and such flexibility in specialization is often touted by both professions as a positive attribute to prospective students.

The underlying education and clinical training of both nurse practitioners and physician assistants is founded upon a generalist approach. With limited exceptions, there is no focus on specialty care. While state licensure requires graduation from an accredited program and certification by a designated body, physician assistant certification and most nurse practitioner certifications are extremely broad, allowing wide latitude in the patient population, specialty or setting in which they can practice.

Moreover, there are little-to-no guardrails limiting the specialties in which nurse practitioners and physician assistants may work. In fact, many studies show a misalignment between nurse practitioner education, training, and certification and the specialty or setting in which they practice, such that some nurse practitioners find themselves in the position of caring for a patient population or level of acuity in which they have received no formal education or training. For both professions, on-the-job training post-graduation is a common means to gain the requisite

knowledge in the specialty and practice setting in which they practice. This reinforces the importance of physician-led team-based care.

While studies demonstrate the increased number of nurse practitioners and physician assistants practicing in specialties as opposed to primary care, there is no publicly available data on specialty switching by nurse practitioners. There are also no studies on the impact of specialty switching on the cost and quality of care provided by nurse practitioners and physician assistants. Moreover, there are no studies on the additional workload placed on physicians and other health care professionals who must provide on-the-job training to nurse practitioners or physician assistants who have switched specialties and/or are practicing in a specialty in which they have no formal education, training, or certification. Moreover, there are no studies looking at the impact of specialty switching in these professions on physician burnout, nor are there studies that look at the impact on physician's time away from providing direct patient care. These gaps in literature are ripe for analysis, particularly by those conducting research on the health care workforce. State nursing and medical boards could also capture this information as part of a survey conducted at the time of licensure renewals by nurse practitioners and physician assistants.

RECOMMENDATIONS

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

1. That the American Medical Association (AMA) support workforce research, including surveys by state medical and nursing boards, that specifically focus on gathering information on nurse practitioners and physician assistants practicing in specialty care, their certification(s), alignment of their certification to their specialty, and whether they have switched specialties during their career.
2. That the AMA support research that evaluates the impact of specialty switching by nurse practitioners and physician assistants on the cost and quality of patient care.
3. That the AMA encourage hospitals and other health care entities employing nurse practitioners and physician assistants to ensure that the practitioner's certification aligns with the specialty in which they will practice.
4. That the AMA continue educating policymakers and lawmakers on the education, training, and certification of nurse practitioners and physician assistants, including the concept of specialty switching
5. Our AMA continue to support research into the cost and quality of primary care delivered by nurse practitioners and physician assistants.
6. That our AMA continue to support research into the distribution and impact of nurse practitioners and physician assistants on primary care in underserved areas.
7. That our AMA continue to support expansion of access to physicians in under resourced areas.

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15. AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED FOR REPORT AT I-24

[Editor's Note: BOT 15 was considered with Resolutions 202 and 246 which were also referred for report at I-24.]

INTRODUCTION

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted policy H-480-935, "Assessing the Potentially Dangerous Intersection Between AI and Misinformation." This policy calls on the AMA to "study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24." This policy reflects the intense interest and activity in augmented intelligence (AI) prompted by the arrival of OpenAI's ChatGPT and other LLMs/generative AI.

Additionally, at the 2023 Interim Meeting, the AMA HOD referred Resolution 206-I-23, "The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice." Resolution 206-I-23 asked, "that our American Medical Association encourage physicians to educate our patients, the public, and policymakers about the benefits and risks of facing LLMs including GPTs for advice on health policy, information on health care issues influencing the legislative and regulatory process, and for information on scope of practice that may influence decisions by patients and policymakers."

Testimony on Resolution 206-I-23 highlighted the importance of physician understanding of LLMs and the ability to weigh the benefits and risks of these tools as the excitement and eagerness to implement them in everyday practice increases. Testimony emphasized that our AMA is currently in the process of fulfilling the directive in Policy H-480-935 (adopted at A-23) that directs our AMA to study and develop recommendations on the benefits and unforeseen consequences to the medical profession of LLMs, such as GPTs, and other augmented intelligence-

generated medical advice or content. The HOD referred Resolution 206 so that the issues raised in this resolution could be considered along with the issues in Policy H-480.935.

BACKGROUND

The issue of AI first presented itself as an area of potential interest to AMA physicians and medical students that necessitated creation of AMA policy in 2018. At that time, physicians and medical students primarily considered AI-enabled technologies within the context of medical device and clinical decision support (CDS), although administrative applications of AI began to grow exponentially and started to gain traction in the hospital, health system, and insurer space. Since the development of the AMA's foundational AI policy in 2018 and subsequent policy on coverage and payment for AI in 2019, the number of AI-enabled medical devices approved by the U.S. Food and Drug Administration (FDA) has grown to nearly 700. In 2022, the concept of "generative AI" and what it can do became better understood to the public. Generative AI is a broad term used to describe any type of artificial intelligence that can be used to create new text, images, video, audio, code, or synthetic data. Generative AI and LLMs have rapidly transformed the use cases and policy considerations for AI within health care, necessitating updated AMA policy that reflects the rapidly evolving state of the technologies.

AMA policy adopted in 2018 and 2019 enabled the AMA to be a strong advocate on behalf of patients and physicians and has been the bedrock of AMA's advocacy on AI in the form of lobbying key congressional committees, participating in expert panel discussions, creating educational resources, and working with our Federation colleagues at the federal and state levels. However, as AI has rapidly developed beyond AI-enabled medical devices and into LLMs/generative AI, new policy and guidance are needed to ensure that they are designed, developed, and deployed in a manner that is ethical, equitable, responsible, and transparent.

As an initial step, in November 2023, the AMA Board of Trustees approved a set of advocacy principles developed by the Council on Legislation (COL) that serve as the framework of this Board report. The main topics addressed in the principles include AI oversight, disclosure requirements, liability, data privacy and security, and payor use of AI. In addition to the COL, these principles have been vetted among multiple AMA business units, and AMA staff has worked with several medical specialty societies that have an expertise in AI and has received additional guidance and input from outside experts that have further refined these principles. These principles build upon and are supplemental to the AMA's existing AI policy, especially
Policy H-480.940, "Augmented Intelligence in Health Care," Policy H-480.939, "Augmented Intelligence in Health Care," and Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization," as well as the AMA's Privacy Principles. The Board recommends adoption of these principles as AMA policy to guide our AMA's advocacy and educational efforts on LLM/generative AI issues.

This report highlights the AMA's recognition of the issues raised at both the A-23 and I-23 HOD meetings, introduces and explains major themes of the report's recommendations, and provides background information on the evolution of AI policy in health care and the direction that policy appears to be headed.

CURRENT STATUS OF OVERSIGHT OF AUGMENTED INTELLIGENCE-ENABLED TECHNOLOGIES

There is currently no whole-of-government strategy for oversight and regulation of AI. The U.S. Department of Health and Human Services (HHS) did establish an AI Office in March 2021 and developed a general strategy to promote the use of trustworthy AI, but has not produced a department-wide plan for the oversight of AI. While many other federal departments and agencies also have some authority to regulate health care AI, many regulatory gaps exist. To address the lack of a national strategy and national governance policies directing the development and deployment of AI, the federal government has largely defaulted to public "agreements" representing promises by large AI developers and technology companies to be good actors in their development of AI-enabled technologies.

In December 2023, the Biden Administration released a reasonably comprehensive executive order on the "Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence." While the executive order does not create new statutory or regulatory requirements, it does serve to direct federal departments and agencies to take action to provide guidance, complete studies, identify opportunities, etc. on AI across several sectors, including HHS. The AMA was pleased to see close alignment between the executive order's direction and AMA principles. However, executive orders do not represent binding policy, so the regulatory status quo remains unchanged at present.

The Biden Administration had also previously released a "Blueprint for an AI Bill of Rights" setting forth five principles that should guide the design, use, and deployment of AI. Those include recommendations for creating safe and effective systems; algorithmic discrimination protections; data privacy; notice and explanation; and human alternatives, considerations, and fallback. Like executive orders, this blueprint does not create new or binding policy and it does not appear there have been new efforts by federal departments and agencies to take action to ensure that AI aligns with these principles.

There have been few, but notable, additional actions by federal agencies that may serve to impact patient and physician interaction with AI-enabled technologies. In 2022, the Centers for Medicare & Medicaid Services (CMS) and HHS Office for Civil Rights (OCR) introduced a sweeping liability proposal within its Section 1557 Non-Discrimination in Health Programs and Activities proposed rule. The proposal, if finalized, would create liability for physicians if they "rely" on a clinical algorithm that results in discriminatory harm to a patient. In the proposal, "clinical algorithm" is defined to include AI. The AMA submitted detailed comments opposing this section of the proposed rule. CMS and OCR have yet to finalize the rule.

In addition, the Office of the National Coordinator for Health Information Technology (ONC) proposed and finalized, with some modifications, polices that will require electronic health record (EHR) technology developers to make certain information about AI used in EHRs available to physicians and other users. ONC refers to these AI tools as Predictive Decision Support Interventions (Predictive DSI). Starting in 2025, EHR developers that supply Predictive DSIs as part of the developer's EHR offering must disclose specific attributes and inform users if patient demographic, social determinants of health, or health assessment data are used in the Predictive DSI. EHRs will be subject to regulatory requirements regarding the design, development, training, and evaluation of Predictive DSIs along with mandated risk management practices. ONC's stated goal is to ensure that physicians understand how these tools work, how data are used, the potential for bias, and any known limitations.

FDA APPROVED AI-ENABLED MEDICAL DEVICES

The FDA continues to rapidly approve AI-enabled medical devices. While FDA approval and clearance of algorithmic-based devices dates back to 1995, clearance and approval of these devices has rapidly accelerated in the last several years. As of October 2023, 692 devices that FDA classifies as Artificial Intelligence/Machine Learning (AI/ML) devices have been approved for marketing. The overwhelming number of these devices are classified as radiology devices and this category of devices has seen the steadiest increases in the number of applications for FDA approval. However, the number of applications is increasing in several specialties, including cardiology, neurology, hematology, gastroenterology, urology, anesthesiology, otolaryngology, ophthalmology, and pathology. A significant number of cleared or approved devices are considered diagnostic in nature and many currently support screening or triage functions.

In 2017, the FDA announced that they were evaluating a potentially new regulatory approach towards Software as a Medical Device, which would include AI/ML technologies. The so-called Pre-Certification program, or "Pre-Cert," progressed to an initial pilot program involving nine manufacturer applicants. The program proposed to pre-certify manufacturers of software-based medical devices. Devices developed by pre-certified manufacturers would be subject to varying levels of FDA review based on risk to patients, including potentially being exempt from review if the risk is low. However, the Pre-Cert program has been tabled and the pilot dismantled for the time being, leaving FDA to utilize traditional review pathways for AI-enabled medical devices. In the absence of new regulatory strategies tailored to SaMD and AI/ML, FDA has issued some proposed guidance for developers of these devices but has not yet moved forward with additional guidance for important, physician-facing topics, such as transparency and labeling requirements. While transparency was listed as one of five major FDA priorities in this area, the Agency does not have current plans to move forward on additional guidance at this time. This leaves a critical gap in the oversight of AI-enabled medical devices.

Data Privacy and Cybersecurity Considerations in Health Care AI

The integration of AI into health care signifies a transformative era, greatly enhancing patient care and operational efficiency. However, this advancement also introduces considerable challenges, particularly in data privacy and cybersecurity. As health care facilities, technology vendors, clinicians, and users increasingly adopt AI, it is vital to focus on protecting patient and user data and securing AI systems against cyber threats. Handling vast amounts of sensitive data raises critical questions about privacy and security. Survey data has shown that 9 out of 10 patients believe privacy is a right and nearly 75 percent of people are concerned about protecting the privacy of their health

data.[1] Addressing these concerns necessitates a multifaceted approach that includes advanced data privacy techniques, data use transparency, robust cybersecurity strategies, and compliance with regulatory standards.

Ensuring the protection of patient data in the context of AI requires sophisticated privacy techniques. Key methods such as anonymization and pseudonymization can remove or replace personal identifiers in data sets and significantly reduce the risk of re-identification. Additionally, implementing a robust data management system empowers patients by providing clear ways to grant, deny, or revoke consent for the use of their data, enhancing patient trust and ensuring compliance with global data protection regulations such as the General Data Protection Regulation and the Health Insurance Portability and Accountability Act (HIPAA). Moreover, the collection of data should be kept to a minimum. By collecting only the data necessary for the intended purpose, AI systems can mitigate the risks associated with data breaches and misuse.

Cybersecurity plays a crucial role in health care, especially in the context of the increasing digitalization of medical records, patient data, and health care services. The health care sector is a prime target for cyber-attacks due to the sensitivity and value of the data it handles, including personal health information (PHI), financial data, and intellectual property related to medical research. The integration of technology in health care has undoubtedly brought significant benefits such as improved patient care, streamlined operations, and enhanced data analytics. However, it also introduces vulnerabilities. These include potential unauthorized access, data breaches, and disruptions to health care services, which can have dire consequences for patient privacy and safety. In 2017, 83 percent of surveyed physicians had already experienced a cyberattack and 85 percent stated that they want to share electronic PHI but were concerned about the data security necessary to protect it.[2] This risk is amplified by the recent increased use of interconnected devices and systems, such as EHRs, telemedicine platforms, and mobile health applications.

The attack on Change Healthcare in February 2024 is a stark reminder of the critical importance of cybersecurity in health care. Change Healthcare, a division of UnitedHealth Group, was struck by a ransomware attack that significantly disrupted the largest health care payment and operations system in the United States. This incident led to widespread disruptions, affecting thousands of medical practices, hospitals, pharmacies, and others. The attack was attributed to ransomware. Despite efforts to recover from this attack, the impact on health care operations was profound, including the disruption of claims processing, payments, and electronic prescriptions leading to financial strain on physicians and delays in patient care. The health care sector's reliance on interconnected digital systems for patient records, billing, and payments, means that the impact of a cyberattack can be both immediate and widespread, affecting patient care and operational continuity.

The implications of cybersecurity in health care AI are multifaceted. AI in health care, encompassing machine learning algorithms, predictive analytics, and robotic process automation, hold immense potential for diagnostic accuracy, personalized medicine, and operational efficiency. However, the deployment of AI in health care settings creates unique cybersecurity challenges. AI systems require large datasets to train and operate effectively, increasing the risk of large-scale data breaches. Additionally, the complexity of AI algorithms can make them opaque and vulnerable to manipulation, such as adversarial attacks that can lead to misdiagnoses or inappropriate treatment recommendations. AI-driven health care solutions often rely on continuous data exchange across networks, escalating the risk of cyber-attacks that can compromise both the integrity and availability of critical health care services.

Model stealing attack represents a significant cybersecurity threat in the realm of AI, where a malicious actor systematically queries an AI system to understand its behavior and subsequently replicates its functionality. This form of intellectual property theft is particularly alarming due to the substantial resources and time required to develop sophisticated AI models. An example of this issue involves a health care organization that has invested heavily in an AI model designed to predict patient health outcomes based on a wide range of variables. If a malicious entity were to engage in model stealing by extensively querying this predictive model, it could essentially duplicate the original model’s predictive capabilities along with capitalizing on sensitive health care information and physicians, users, or the entity’s intellectual property. Absent strong protections against input manipulation and malicious attacks, AI can become a new conduit for bad actors to compromise health care organizations and harm patients. This not only undermines the original investment but also poses a direct threat to the competitive advantage of the innovating organization.

Moreover, the risk extends beyond intellectual property theft to encompass serious privacy concerns. This is exemplified by incidents where generative AI models, trained on vast datasets, inadvertently reveal sensitive

information contained within their training data in response to certain prompts. In the health care sector, where models are often trained on highly sensitive patient data, including personally identifiable information, the unauthorized extraction of this data can lead to significant breaches of patient confidentiality. The dual threat of intellectual property theft and data privacy breaches underscores the critical need for robust cybersecurity measures in safeguarding AI models, particularly those developed and utilized within the health care industry, to maintain the integrity of both their intellectual property and the confidentiality of the sensitive data they handle.

While there are new federal policies to increase data transparency when AI is used in conjunction with health information technology, such as those issued by ONC, these new policies only cover the certified EHR developer and stop short of holding AI developers accountable for robust data governance or data security and privacy practices.[3]

GENERATIVE AI

The broad introduction of generative AI into the public sphere in 2022 saw a paradigm shift in how physicians contemplated AI. Open-source LLM Chat GPT presented a new, easily accessible AI-enabled technology with significant capabilities to generate new content and provide readily available access to information from a huge number of sources. Generative AI tools have significant potential to relieve physician administrative burdens by helping to address actions such as in-box management, patient messages and prior authorization requests. They also show promise in providing clinical decision support. These generative AI tools, however, can also pose significant risk, particularly for clinical applications. They are largely unregulated, as there is no current regulatory structure for generative AI clinical decision support tools unless they meet the definition of a medical device regulated by the FDA. The U.S. Federal Trade Commission (FTC) has limited authority to regulate data privacy issues that may be associated with generative AI tools. The FTC can also regulate activities considered to be an unfair, deceptive, or abusive business practice and can enforce laws for consumer protection. CMS has some authority to regulate use of AI by entities receiving funds from Medicare and Medicaid, including use by Medicare Advantage plans. OCR has some additional authorities to regulate data privacy and nondiscrimination. CMS and OCR have already put forth a very concerning proposal regarding physician liability for clinical algorithms, which the AMA has vigorously opposed.

While some federal agencies may have oversight and authorities to regulate some aspects of AI, there are many regulatory gaps. These regulatory gaps are particularly significant when considering generative AI, as tools like ChatGPT and others currently fall well outside the definition of a regulated medical device. While generative AI use for clinical applications is relatively limited right now, it is expected to grow and patients and physicians will need assurances that it is providing safe, correct, non-discriminatory answers to the full extent possible, whether through regulation or generally accepted standards for design, development, and deployment.

USE OF AI BY PAYORS

There have been numerous reports recently regarding the use of what has been termed “automated decision-making tools” by payors to process claims. However, numerous reports regarding the use of these tools show a growing tendency toward inappropriate denials of care or other limitations on coverage. Reporting by ProPublica claims that tools used by Cigna denied 300,000 claims in two months, with claims receiving an average of 1.2 seconds of review.[4] Two class action lawsuits were filed during 2023, charging both United Health Care and Humana with inappropriate claims denials resulting from use of the nHPredict AI model, a product of United Health Care subsidiary NaviHealth. Plaintiffs in those suits claim the AI model wrongfully denied care to elderly and disabled patients enrolled in Medicare Advantage (MA) plans with both companies. Plaintiffs also claim that payors used the model despite knowing that 90 percent of the tool’s denials were faulty.

There is growing concern among patients and physicians about what they perceive as increasing and inappropriate denials of care resulting from the use of these automated decision-making tools. In his recent Executive Order on AI, President Biden addressed this issue as an area of concern, directing the HHS to identify guidance and resources for the use of predictive and generative AI in many areas, including benefits administration, stating that it must take into account considerations such as appropriate human oversight of the application of the output from AI.

There are currently no statutory and only limited regulatory requirements addressing the use of AI and other automated decision-making tools by payors. States are beginning to look more closely at this issue given the significant negative reporting in recent months and are a likely place for near-term action on this issue. Congress has

also shown increasing concern and has convened hearings for testimony on the issue; however, there has been no further Congressional action or legislation to pursue further limitations on use of these algorithms. Additionally, CMS has not taken broad regulatory action to limit the use of these algorithms by entities administering Medicare and Medicaid benefits.

AMA POLICY

The AMA has existing policies, H-480.940 and H-480.939 both titled "Augmented Intelligence in Health Care," which stem from a 2018 and 2019 Board report and cover an array of areas related to the consequences and benefits of AI use in the physician's practice. In pertinent part to this discussion, AMA Policy H-480.940 seeks to "promote development of thoughtfully designed, high-quality, clinically validated health care AI, encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI, and explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI." This policy reflects not only the significance of attribution on the part of the developer, but furthermore emphasizes that physicians and other end users also play a role in understanding the technology and the risks involved with its use.

AMA Policy H.480.939 also addresses key aspects of accountability and liability by stating that "oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment." Furthermore, this policy asserts that "liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Specifically, developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users."

AMA Policy D-480.956 supports "greater regulatory oversight of the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers are using a thorough and fair process that: (1) is based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature; (2) includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review; and (3) requires such reviews include human examination of patient records prior to a care denial."

DISCUSSION

As the number of AI-enabled health care tools and systems continues to grow, these technologies must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, and transparent. With a lagging effort towards adoption of national governance policies or oversight of AI, it is critical that the physician community engage in development of policies to help drive advocacy, inform patient and physician education, and guide engagement with these new technologies. It is also important that the physician community help guide development of these tools in a way that best meets both patient and physician needs, and help define their own organization's risk tolerance, particularly where AI impacts direct patient care. AI has significant potential to advance clinical care, reduce administrative burdens, and improve clinician well-being. This may only be accomplished by ensuring that physicians engage only with AI that satisfies rigorous, clearly defined standards to meet the goals of the quadruple aim:[5] advance health equity, prioritize patient safety, and limit risks to both patients and physicians.

Oversight of Health Care Augmented Intelligence

There is currently no national policy or governance structure in place to guide the development and adoption of non-device AI. As discussed above, the FDA regulates AI-enabled medical devices, but many types of AI-enabled technologies fall outside the scope of FDA oversight[6]. This potentially includes AI that may have clinical applications, such as some generative AI technologies serving clinical decision support functions. While the FTC and OCR have oversight over some aspects of AI, their authorities are limited and not adequate to ensure appropriate development and deployment of AI generally, and specifically in the health care space. Likewise,

ONC's enforcement is limited and focused on EHR developers' use and integration of AI within their federally certified EHRs. While this is a major first step in requiring AI transparency, it is still the EHR developer that is regulated with few requirements on the AI developer itself. Encouragement of a whole-of-government approach to implement governance policies will help to ensure that risks to consumers and patients arising from AI are mitigated to the greatest extent possible.

In addition to the government, health care institutions, practices, and professional societies share some responsibility for appropriate oversight and governance of AI-enabled systems and technologies. Beyond government oversight or regulation, purchasers and users of these technologies should have appropriate and sufficient policies in place to ensure they are acting in accordance with the current standard of care. Similarly, clinical experts are best positioned to determine whether AI applications are high quality, appropriate, and whether the AI tools are valid from a clinical perspective. Clinical experts can best validate the clinical knowledge, clinical pathways, and standards of care used in the design of AI-enabled tools and can monitor the technology for clinical validity as it evolves over time.

Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies

As implementation of AI-enabled tools and systems increases, it is essential that use of AI in health care be transparent to both patients and physicians. Transparency requirements should be tailored in a way that best suits the needs of the end users. Care must be taken to preserve the integrity of data sets used in health care such that individual choice and data privacy are balanced with preserving algorithms that remain as pristine as possible to avoid exacerbating health care inequities. Disclosure should contribute to patient and physician knowledge without increasing administrative burden. When AI is utilized in health care decision-making, that use should be disclosed and documented to limit risks to, and mitigate inequities for, both patients and physicians, and to allow each to understand how decisions impacting patient care or access to care are made. While transparency does not necessarily ensure AI-enabled tools are accurate, secure, or fair, it is difficult to establish trust if certain characteristics are hidden.

Heightened attention to transparency and additional transparency requirements serve several purposes. They help to both ensure that the best possible decisions are made about a patient's health care and help patients and physicians identify critical decision points and possible points of error. They can also serve as mechanisms to help shield physicians from liability so that potential issues related to use of AI-enabled technologies can be isolated and accountability apportioned appropriately.

There are currently few federal requirements for transparency regarding AI. The FDA requires product labeling to provide certain information to physicians and other users, but requirements for device labeling are generally considered to be less stringent and have more leeway than drug product labeling. While FDA has stated that transparency is a key priority for the agency to address, they have not taken any additional action to update the labeling requirements for AI-enabled medical devices or put into place additional transparency requirements for AI-enabled devices. As discussed above, ONC also has new transparency requirements applicable to the use of AI within EHRs; however, again, those requirements are limited to AI within an EHR or other applications integrated and made available through the EHR. They will not apply to AI-enabled tools accessible through the Internet, cellular phones, etc. It is clear that there is an urgent need for additional federal action to ensure AI transparency.

Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies

Along with significant opportunity to improve patient care, all new technologies in health care will likely present certain risks and limitations that physicians must carefully navigate during the early stages of clinical implementation of these new systems and tools. AI-enabled tools are no different and are perhaps more challenging than other advances as they present novel and complex questions and risks. To best mitigate these risks, it is critical that physicians understand AI-driven technologies and have access to certain information about the AI tool or system being considered, including how it was trained and validated, so that they can assess the quality, performance, equity, and utility of the tool to the best of their ability. This information may also establish a set of baseline metrics for comparing AI tools. Transparency and explainability regarding the design, development, and deployment processes should be mandated by law where feasible, including potential sources of inequity in problem formulation, inputs, and implementation. Additionally, sufficient detail should be disclosed to allow physicians to determine whether a given AI-enabled tool would reasonably apply to the individual patient they are treating.

Physicians should be aware and understand that, where they utilize AI-enabled tools and systems without transparency provided by the AI developer, their risks of liability for reliance on that AI will likely increase. The

need for full transparency is greatest where AI-enabled systems have greater impact on direct patient care, such as by AI-enabled medical devices, clinical decision support, and interaction with AI-driven chatbots. Transparency needs may be somewhat lower where AI is utilized for primarily administrative, practice-management functions. While some of this information may be provided in labeling for FDA cleared and approved medical devices, the labeling requirements for such devices have not been specifically tailored to clearly convey information about these new types of devices. Updated guidance for FDA-regulated medical devices is needed to provide this critical information. Congress should consider actions to ensure appropriate authorities exist to require appropriate information to be provided to users of AI so that they can best evaluate the technology to determine reported performance, intended use, intended population, and appropriateness for the task. Developers and vendors should consider voluntarily providing this information about their products, and physicians and other purchasers should consider this information when selecting the AI tools they use.

Generative AI

Generative AI is a type of AI that can recognize, summarize, translate, predict, and generate text and other content based on knowledge gained from large datasets. Generative AI tools are finding an increasing number of uses in health care, including assistance with administrative functions, such as generating office notes, responding to documentation requests, and generating patient messages. Additionally, there has been increasing discussion about clinical applications of generative AI, including use as clinical decision support to provide differential diagnoses, early detection and intervention, and to assist in treatment planning. While generative AI tools show tremendous promise to make a significant contribution to health care, there are a number of risks and limitations to consider when using these tools in a clinical setting or for direct patient care. These risks are especially important to consider for clinical applications that may impact clinical decision-making and treatment planning where risks to patients are higher.

Given that there are no regulations or generally accepted standards or frameworks to govern the design, development, and deployment of generative AI, consideration and mitigation of the significant risks is paramount. To manage risk, health care organizations should develop and adopt appropriate polices that anticipate and minimize negative impacts. Physicians who consider utilizing a generative AI-based tool in their practice should ensure that all practice staff are educated on the risks and limitations, including patient privacy concerns, and should have appropriate governance policies in place for its use prior to adoption. Also, as raised in Resolution 206-I-23, physicians should be encouraged to educate their patients about the benefits and risks of using AI-based tools, such as LLMs, for information about health care conditions, treatment options, or the type of health care professionals who have the education, training, and qualifications to treat a particular condition. Patients and physicians should be aware that chatbots powered by LLMs/generative AI could provide inaccurate, misleading, or unreliable information and recommendations. This principle is incorporated in the recommendations in this report and current AMA Policy H-480.940, "Augmented Intelligence in Health Care."

Liability

The question of physician liability for use of AI-enabled technologies presents novel and complex legal questions and poses risks to the successful clinical integration of AI-enabled technologies. It is also one of the most serious concerns for physicians when considering integration of AI into their practice. Concerns also arise for employed physicians who feel they may have no choice but to utilize the AI, should hospitals or health systems mandate its use or utilize an EHR system that incorporates AI-based applications as standard.

The challenge for physicians regarding questions of liability for use of AI is that there is not yet any clear legal standard for determining liability. While there are clear standards for general medical malpractice and for medical device liability, AI presents novel and potentially complex legal questions. When AI has suggested a diagnosis, the question of how appropriate it is for a physician to rely on that result is yet to be determined and will likely continue to evolve as AI improves. Ultimately the "standard of care" will help guide physician liability. It is expected that, as it improves over time, AI will be incorporated into what is likely to be specialty-specific standards of care. However, until that occurs, AI-transparency is of critical importance and physicians will need to be diligent in ensuring that they engage with AI tools where performance has been validated in their practice setting.

As AI continues to evolve, there may ultimately be questions regarding liability when physicians fail to use AI and rely only on their professional judgment. Again, this question may ultimately turn on what evolves to be considered the standard of care.

It should be noted that, when using AI, physicians will still be subject to general legal theories regarding medical liability. Negligent selection of an AI tool, including using tools outside their intended use or intended population, or choosing a tool where there is no evidence of clinical validation, could be decisions that expose a physician to a liability claim.

Data Privacy and Augmented Intelligence

Data privacy is highly relevant to AI development, implementation, and use. The AMA is deeply invested in ensuring individual patient rights and protections from discrimination remain intact, that these assurances are guaranteed, and that the responsibility rests with the data holders. AI development, training, and use requires assembling large collections of health data. AI machine learning is data hungry; it requires massive amounts of data to function properly. Increasingly, more electronic health records are interoperable across the health care system and, therefore, are accessible by AI trained or deployed in medical settings. AI developers may enter into legal arrangements (e.g., business associate agreements) that bring them under the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. While some uses of AI in health care, such as research, are not allowed by HIPAA absent patient authorization, the applicability of other HIPAA privacy protections to AI use is not as clear and HIPAA cannot protect patients from the "black box" nature of AI which makes the use of data opaque. AI system outputs may also include inferences that reveal personal data or previously confidential details about individuals. This can result in a lack of accountability and trust and exacerbate data privacy concerns. Often, AI developers and implementers are themselves unaware of exactly how their products use information to make recommendations.

It is unlikely that physicians or patients will have any clear insight into a generative AI tool's conformance to state or federal data privacy laws. LLMs are trained on data scraped from the web and other digital sources, including one well-documented instance where HIPAA privacy protections were violated.[7] Few, if any, controls are available to help users protect the data they voluntarily enter in a chatbot query. For instance, there are often no mechanisms in place for users to request data deletion or ensure that their inputs are not stored or used for future model training. While tools designed for medical use should align with HIPAA, many "HIPAA-compliant" generative tools rely on antiquated notions of deidentification, i.e., stripping data of personal information. With today's advances in computing power, data can easily be reidentified. Rather than aiming to make LLMs compliant with HIPAA, all health care AI-powered generative tools should be designed from the ground up with data privacy in mind.

The AMA's Privacy Principles were designed to provide individuals with rights and protections and shift the responsibility for privacy to third-party data holders. While the Principles are broadly applicable to all AI developers, e.g., entities should only collect the minimum amount of information needed for a particular purpose, the unique nature of LLMs and generative AI warrant special emphasis on entity responsibility and user education.

Augmented Intelligence Cybersecurity

Data privacy relies on strong data security measures. There is growing concern that cyber criminals will use AI to attack health care organizations. AI poses new threats to health IT operations. AI-operated ransomware and AI-operated malware can be targeted to infiltrate health IT systems and automatically exploit vulnerabilities. Attackers using ChatGPT can craft convincing or authentic emails and use phishing techniques that entice people to click on links—giving them access to the entire electronic health record system.

AI is particularly sensitive to the quality of data. Data poisoning is the introduction of "bad" data into an AI training set, affecting the model's output. AI requires large sets of data to build logic and patterns used in clinical decision-making. Protecting this source data is critical. Threat actors could also introduce input data that compromises the overall function of the AI tool. Failure to secure and validate these inputs, and corresponding data, can contaminate AI models—resulting in patient harm.

Because stringent privacy protections and higher data quality standards might slow model development, there could be a tendency to forgo essential data privacy and security precautions. However, strengthening AI systems against cybersecurity threats is crucial to their reliability, resiliency, and safety.

Payor Use of Augmented Intelligence in Automated Decision-Making

Payors and health plans are increasingly using AI and algorithm-based decision-making in an automated fashion to determine coverage limits, make claim determinations, and engage in benefit design. Payors should leverage automated decision-making systems that improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. While the use of these systems can create efficiencies such as speeding up prior authorization and cutting down on paperwork, there is concern these systems are not being designed or supervised effectively—creating access barriers for patients and limiting essential benefits. Increasingly, evidence indicates that payors are using automated decision-making systems to deny care more rapidly, often with little or no human review. This manifests in the form of increased denials, stricter coverage limitations, and constrained benefit offerings. For example, a payor allowed an automated system to cut off insurance payments for Medicare Advantage patients struggling to recover from severe diseases, forcing them to forgo care or pay out of pocket. In some instances, payors instantly reject claims on medical grounds without opening or reviewing the patient's medical record. There is also a lack of transparency in the development of automated decision-making systems. Rather than payors making determinations based on individualized patient care needs, reports show that decisions are based on algorithms developed using average or "similar patients" pulled from a database. Models that rely on generalized, historical data can also perpetuate biases leading to discriminatory practices or less inclusive coverage.[8,9,10,11]

While AI can be used inappropriately by payors with severe detrimental outcomes to patients, it can also serve to reduce administrative burdens on physicians, providing the ability to more easily submit prior authorization and documentation requests in standardized forms that require less physician and staff time. Given the significant burden placed on physicians and administrative staff by prior authorization requests, AI could provide much needed relief and help to increase professional satisfaction among health care professionals. With clear guidelines, AI-enabled decision-making systems may also be appropriate for use in some lower-risk, less complex care decisions.

While payor use of AI in well-defined situations with clear guidelines has the potential to reduce burdens and benefit physician practices, new regulatory or legislative action is necessary to ensure that automated decision-making systems do not reduce needed care, nor systematically withhold care from specific groups. Steps should be taken to ensure that these systems do not override clinical judgment. Patients and physicians should be informed and empowered to question a payor's automated decision-making. There should be stronger regulatory oversight, transparency, and audits when payors use these systems for coverage, claim determinations, and benefit design. [See Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization;" Policy H-320.939, "Prior Authorization and Utilization Management Reform"]

CONCLUSION

As the number of AI-enabled health care tools and systems continue to grow, these technologies must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, and transparent. In line with AMA Policy H-480-935 and Resolution 206-I-23, this report highlights some of the potential benefits and risks to the medical profession and patients of LLMs (e.g., GPTs) and other AI-generated medical decision-making tools, and recommends adoption of policy to help inform patient and physician education and guide engagement with this new technology, as well as position the AMA to advocate for governance policies that help to ensure that risks arising from AI are mitigated to the greatest extent possible.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 206-I-23 and that the remainder of the report be filed:

AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE

General Governance

- Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, and transparent.

- Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
- Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
- Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the potential overall of disparate harm and consequences the AI system might introduce. [See also Augmented Intelligence in Health Care H-480.939 at (1)]
- Clinical decisions influenced by AI must be made with specified human intervention points during the decision-making process. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan.
- Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow.
- Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies

- When AI is used in a manner which directly impacts patient care, access to care, or medical decision making, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
- When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
- AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
- When health care content is generated by generative AI, including by large language models, it should be clearly disclosed within the content that was generated by an AI-enabled technology.
- When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
- The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology.

What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies

- When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
    - Regulatory approval status
    - Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology
    - Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use
    - Intended population and intended practice setting
    - Clear description of any limitations or risks for use, including possible disparate impact
    - Description of how impacted populations were engaged during the AI lifecycle
    - Detailed information regarding data used to train the model:
        - Data provenance
        - Data size and completeness

        - Data timeframes
        - Data diversity
        - Data labeling accuracy
    - Validation Data/Information and evidence of:
        - Clinical expert validation in intended population and practice setting and intended clinical outcomes
        - Constraint to evidence-based outcomes and mitigation of "hallucination" or other output error
        - Algorithmic validation
        - External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation
        - Comprehensiveness of data and steps taken to mitigate biased outcomes
        - Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings
        - Post-market surveillance activities aimed at ensuring continued safety, performance, and equity
    - Data Use Policy
        - Privacy
        - Security
        - Special considerations for protected populations or groups put at increased risk
    - Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training
    - Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review

- Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

Generative Augmented Intelligence

- Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
- Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
    - Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response
    - Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations
    - Lack of regulatory or clinical oversight to ensure performance of the tool
    - Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes
    - Data privacy
    - Cybersecurity
    - Physician liability associated with the use of generative AI tools
- Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
- Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.

- Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (e.g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
- Governance policies should prohibit the use of confidential, regulated, or proprietary information as prompts for generative AI to generate content.
- Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.

Physician Liability for Use of Augmented Intelligence-Enabled Technologies

- Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
    - Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
    - Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    - Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
- When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.

Data Privacy and Augmented Intelligence

- Entity Responsibility:
    - Entities should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
    - Individuals should have the right to opt-out, update, or forget use of their data in generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
    - Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.

- User Education:
    - Users should be provided with training specifically on generative AI. Education should address:
        - legal, ethical, and equity considerations;
        - risks such as data breaches and re-identification;
        - potential pitfalls of inputting sensitive and personal data; and
        - the importance of transparency with patients regarding the use of generative AI and their data.

    [See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

Augmented Intelligence Cybersecurity

- AI systems must have strong protections against input manipulation and malicious attacks.
- Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.

- Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
- Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.

Payor Use of Augmented Intelligence and Automated Decision-Making Systems

- Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
- Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
- Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
- Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
- Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
- Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
- Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

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16. SUPPORT FOR MENTAL HEALTH COURTS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 202-A-23
REMAINDER OF REPORT FILED
See Policy H-100.955

INTRODUCTION

At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 202 entitled, "Support for Mental Health Courts," was introduced by the Medical Student Section and called on the AMA to amend existing policy – Policy H-100.955 entitled, "Support for Drug Courts" – as follows:

> Our AMA: (1) supports the establishment and use of mental health ~~drug~~ courts, including drug courts and sobriety courts, as an effective method of intervention within a comprehensive system of community-based supports and services for individuals with mental illness involved in the justice system ~~addictive disease who are convicted of nonviolent crimes~~; (2) encourages legislators to establish mental health ~~drug~~ courts at the state and local level in the United States; and (3) encourages mental health ~~drug~~ courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.

There was robust discussion of this resolution, including widespread support for increasing access to evidence-based care for individuals with a mental illness or substance use disorder (SUD) who were involved with the justice system. Multiple questions were raised, however, regarding terms of art that may be in use in legal settings compared to medical settings; the potential of unintended consequences; and the different uses of such courts. Ultimately, the HOD referred this resolution to the Board of Trustees for study. In response, this report provides background information; discusses the different courts; presents AMA policy; and makes recommendations.

BACKGROUND

There are more than 4,000 courts in the United States that provide some measure of alternative to incarceration when there is evidence of a mental illness, SUD, or other health condition impacting an individual and/or family.[1] There are at least 39 states with a diversion program that addresses substance use, and at least 24 that directly address mental health and illness needs.[2] A fact sheet from the Obama Administration noted that, "Since 1989, drug courts have been established or are being planned in all 50 States, the District of Columbia, the Northern Mariana Islands, Puerto Rico, Guam, and in nearly 90 Tribal locations."[3] The AMA has long been a supporter of these programs.[4]

These programs go by many names, including "treatment court," "adult drug court," "DWI court," "family treatment court," "juvenile treatment court," "tribal healing to wellness court," or "veterans treatment court." Other names used to describe programs that seek alternatives to incarceration are "opioid intervention court," "opiate treatment court," "heroin court," "treatment pathway program," "overdose avoidance and recovery program," and "heroin overdose prevention and education initiative."[5] The U.S. Department of Justice (DOJ) broadly describes these programs as "pretrial diversion programs" to which the U.S. Attorney has discretion to "divert" if there are "substance abuse or mental health challenges."[6]

Given the many different types of programs that are designed to provide mental health or SUD services as an alternative to incarceration, for the purposes of this report, any program that addresses substance use or mental health in a justice-involved or justice-related setting or program will be denoted as a "diversion program." A recent issue brief from the National Conference of State Legislatures (NCSL)[7] further explains that "Pretrial diversion programs are post-arrest interventions that occur at some point prior to final entry of judgment. Programs can take place before charges are filed, before first appearance or before adjudication."

Public health and public justice and law enforcement officials generally agree on the considerable need to treat mental illness and SUDs. Data reported by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) show much greater prevalence of mental illness and SUDs in jails and prisons compared to the general population. It is estimated that:[8]

- 18 percent of the general population has a mental illness; 44 percent of those in jail and 37 percent of those in prison have a mental illness;
- 11 percent of 18–25-year-olds, and 6 percent of those over 25 years old have a SUD; and
- 63 percent of people in jail and 58 percent in prison have a SUD.

In terms of sheer numbers, "1.2 million individuals living with mental illness sit in jail and prison each year."[9] Making matters more challenging, more than 60 percent of individuals with a history of mental illness do not receive treatment while incarcerated, and more than 50 percent of individuals receiving medication for mental health conditions stop taking them upon being incarcerated.[10] The National Institutes on Drug Abuse says that estimates for SUD prevalence in jails and prisons have been as high as 65 percent.[11]

DISCUSSION

Are Diversion Programs an Effective Method of Intervention for Individuals with Mental Illness or Substance Use Disorder Involved with the Justice System?

The first issue to address is whether diversion programs are an effective method of intervention for individuals with a mental illness or SUD involved with the justice system. If so, what elements of a diversion program demonstrate efficacy? For the purposes of this report, at least two metrics for "efficacy" can be viewed as to whether individuals receive and continue to engage in treatment, as well as whether they become re-incarcerated. While it is beyond the scope of this report to evaluate the 4,000+ programs in existence in the United States, there are innumerable examples of programs reporting that individuals enrolled in diversion programs not only start and continue treatment but are also less likely to return to jail or prison or be re-arrested. Proponents of diversion programs cite multiple economic and other benefits, including that they can connect hundreds of thousands of individuals to medications for opioid use disorder (OUD).

A sample of meta-analyses also show general positivity, but identify challenges that come with evaluating such programs:

- A 2012 meta-analysis found that adult drug courts are effective "in reducing recidivism…[and] The evidence assessing DWI courts' effectiveness is very promising but more experimental evaluations are needed. Juvenile drug courts typically produce small reductions in recidivism."[12]
- A 2013 meta-review broadly found benefits of juvenile justice diversion programs.[13]
- A 2016 review of juvenile justice programs found, "There is no evidence that juvenile drug courts are more or less effective than traditional court processing in terms of reducing juveniles' recidivism and drug use, but there is also no evidence of harm. The quality of the body of evidence is very low, however, so we have little confidence in these null findings."[14]
- A 2016 guide from the National Drug Court Institute cited multiple studies showing that, "Use of all three [MOUD] medications is associated with significantly reduced use of unauthorized opioids among probationers, parolees, and other persons with opioid use disorders involved in the criminal justice system."[15]
- A 2017 review of mental health courts (MHC) found that, "Overall, a small effect of MHC participation on recidivism was noted, compared with traditional criminal processing. Findings suggest the need for research to identify additional sources of variability in the effectiveness of MHCs."[16]
- A 2019 systematic review of drug courts found that, "Treatment accessed via community-based diversion is effective at reducing drug use in Class A drug-using offenders. Evidence of a reduction in offending amongst this group as a result of diversion is uncertain. Poor methodological quality and data largely limited to US methamphetamine users limits available evidence."[17]
- A 2020 literature review of mental health courts found that, while research generally supports MHCs' positive effects to reduce recidivism, there are inconsistencies with overall study designs, data collection, lack of adequate controls and other methodological faults.[18]
- Another 2020 meta-analysis found that, "diversion programs for low-level drug offenders are likely to be cost-effective, generating savings in the criminal justice system while only moderately increasing healthcare costs. Such programs can reduce incarceration and its associated costs and avert overdose deaths and improve quality of life for PWID [people who inject drugs], PWUD [people who use drugs], and the broader population (through reduced HIV and HCV transmission)."[19]

Considering individual programs reporting broad benefits[20] and meta-analyses showing benefits as well as raising questions about how broad those benefits might be, it seems prudent to call for additional research as well as mechanisms to identify best practices. For example, some programs to treat OUD might prohibit use of medications for opioid use disorder (MOUD) or rely on non-evidence-based approaches. The Board of Trustees notes, however, that what works in one jurisdiction may not work in another—and given the evidence that points to the overall benefits and lack of harm, we believe that the AMA should continue to support these programs. To guide programs, we highlight that professional medical organizations have published multiple guidelines and treatment considerations for diversion programs and care for individuals involved with the justice system, including the American Society of Addiction Medicine,[21] American Psychiatric Association,[22] and Providers Clinical Support System.[23]

There are many potential elements of "a comprehensive system of community-based supports and services." This includes benefits provided by "wraparound services," such as community-based interagency cooperation, care coordination, child and/or family teams, unified plans of care, evidence-based systems of care, and other areas.[24] Additional guidance can be found in recent SAMHSA grants for diversion programs in three jurisdictions.[25] These grants identify multiple types of services that may be useful in a diversion program, including motivational interviewing; crisis intervention training; psychiatric/psychosocial rehabilitation; dialectical behavior therapy; community-based treatment; case management; comprehensive psychiatric services, including psychotherapy and supportive counseling; substance use and detoxification treatment; housing and employment support, including skills training; screening, assessment, referral, and treatment to individuals at risk of entering the criminal justice system; and links between individuals and other community resources. While not all diversion programs will have all these elements, the Board of Trustees believes that the AMA should support development of diversion programs that include broad-based community support that include these types of resources.

Should Diversion Programs be Available to Both Nonviolent and Violent Offenders?

The second issue is whether diversion programs should be available to both nonviolent and violent offenders. It is first important to distinguish that *access to a diversion program* is related to—but different from than *access to evidence-based treatment* for a mental illness or SUD within the justice system. In 2022, the DOJ issued guidance making it clear that the Americans with Disabilities Act (ADA) protects individuals with an OUD to continue treatment for an OUD while incarcerated, including protecting continuity of care with MOUD.[26] The AMA has advocated in multiple legal, legislative, and other forums that individuals involved with the justice system have a medical—and constitutional right—to continue OUD while incarcerated. This advocacy is highlighted in seminal cases: *Smith v. Aroostook County*[27] and *Pesce v. Coppinger.*[28] By extension, an individual also likely has statutory and constitutional rights to MOUD—or other evidence-based care—in a diversion program, but as the DOJ points out, there may be nuances if "the individual is currently engaged in illegal drug use."[29] The National Institute on Drug Abuse (NIDA) explains that:

> The chronic nature of addiction means that for some people relapse, or a return to drug use after an attempt to stop, can be part of the process, but newer treatments are designed to help with relapse prevention. Relapse rates for drug use are similar to rates for other chronic medical illnesses. If people stop following their medical treatment plan, they are likely to relapse.[30]

The Board of Trustees believes that AMA support for individuals being able to stay in treatment even if they engaged in illegal drug use is a natural extension of existing AMA policy to not punish people because they have a SUD.

With respect to whether diversion programs should be available to non-violent and violent offenders, given the evidence showing benefits of these programs—even if limited in some cases—the AMA should continue to support access to evidence-based care, including MOUD, for non-violent offenders. Notably, no change in policy is needed to meet this result. Whether to support and advocate for diversion programs to be available to individuals charged or convicted of violent offenses, however, raises multiple issues.

The first issue is whether those charged or convicted of a violent offense are legally eligible for a diversion program. The U.S. Government Accountability Office (GAO) reports that, "adult drug courts funded by DOJ grants are prohibited by law from using grant funding to include individuals with prior or current violent offenses in their programs."[31] The GAO pointed out, however, that, "a few adult drug courts told us that they admit violent offenders, by ensuring that they do not use federal funding to serve these clients." The GAO, which interviewed representatives from 44 adult drug courts from a mix of rural, suburban, urban, and tribal adult drug courts, highlighted that some violent offenders and those convicted of drug-related crimes would benefit from drug court services. State law also commonly excludes individuals charged or convicted of a violent offense—or having been convicted within a certain time period in the past.

The National Association of Drug Court Professionals counsels that, "Evidence does not support blanket disqualification from treatment court for persons with a history of violent crimes. Instead, persons charged with offenses involving violence, or who have a history of such offenses, should be evaluated on a case-by-case basis to determine if they can be safely supervised in treatment court."[32] The Board of Trustees agrees. Just as AMA policy does not discriminate against an individual's right to receive treatment based on external factors, the AMA should not discriminate against access to evidence-based care for SUD and mental illness based on carceral status or judicial supervision. As noted above, the provision of evidence-based care for mental illness and SUDs has strong constitutional protections. And as discussed below, current AMA policy strongly supports evidence-based care for individuals with a mental illness or SUD in jails and prisons.

Saying that the AMA should not oppose participation in a diversion program does not mean, however, that there should not be comprehensive considerations about which individuals would benefit most from participation in a diversion program. Such considerations, moreover, should include whether an individual's participation constitutes a threat to public safety. Thankfully, there are robust eligibility criteria to help judicial and health care professionals make those determinations. This guidance can help ensure "equitable access, services, and outcomes for all sociodemographic and sociocultural groups," including "guidance for treatment courts to monitor and rectify unwarranted cultural disparities."[33] The eligibility guidance, moreover, can help diversion programs remove inappropriate restrictions and exclusions, ensure evidence-based care, connect individuals to complementary services, as well as avoid conflicts of interest. And just as important, the Board of Trustees agrees that:

> All persons meeting evidence-based eligibility criteria for treatment court receive the same opportunity to participate and succeed in the program regardless of their sociodemographic characteristics or sociocultural identity, including but not limited to their race, ethnicity, sex, gender identity, sexual orientation, age, socioeconomic status, national origin, native language, religion, cultural practices, and physical, medical, or other conditions.[34]

AMA POLICY

A bedrock of AMA advocacy is found in Policy H-430-987, "Medications for Opioid Use Disorder in Correctional Facilities," which provides, "Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated." This policy also calls for the AMA to advocate for

> . . . legislation, standards, policies, and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.

The Board of Trustees recommends that diversion programs be held to the same standards.

The AMA also supports "veterans courts" as "a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder." (Policy H-510-979, "Support for Veterans Courts"). If AMA policy supports broad access to veterans' courts as a matter of policy, the Board of Trustees does not see any reason why such policy should not also apply to other types of diversion programs. Similarly, AMA policy calling to support "justice reinvestment initiatives … and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs," does not distinguish between nonviolent and violent offenses.
(Policy H-94-931, "AMA Support for Justice Reinvestment Initiatives").

Finally, AMA Ethics Policy recognizes that, "Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law." (Policy E-9.7.2, "Court-Initiated Medical Treatment in Criminal Cases"). This policy also counsels for physicians to, "Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered." (Policy E-9.7.2, "Court-Initiated Medical Treatment in Criminal Cases"). Thus, while the justice system may have guidance about which individuals are eligible for a diversion program, the physician's role is not to raise barriers to such care.

RECOMMENDATIONS

The Board of Trustees recommends that existing policy – Policy H-100.955, entitled, "Support for Drug Courts" – be amended by addition and deletion in lieu of Resolution 202 as follows:

> Support for Diversion Programs, Including Drug Courts, Mental Health Courts, Veterans Courts, Sobriety Courts, and Similar Programs
>
> Our AMA:
> (1) supports the establishment and use of diversion and treatment programs ~~drug courts~~, including drug courts, mental health courts, veterans courts, sobriety courts, and other types of similar programs, as an effective method of intervention within a comprehensive system of community-based supports and services for individuals with a mental illness or substance use disorder involved in the justice system ~~addictive disease who are convicted of nonviolent crimes~~;
> (2) encourages legislators and court systems to establish diversion and treatment programs ~~drug courts~~ at the state and local level in the United States; ~~and~~
> (3) encourages diversion and treatment programs ~~drug courts to~~ that rely upon evidence-based models of care, including all medications used for treatment of substance use disorder, for those who the judge or court determine would benefit from intervention, including treatment, rather than incarceration; and

(4) supports individuals enrolled in diversion or treatment programs not be removed from a program solely because of evidence showing that an individual used illegal drugs while enrolled.

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17. DRUG POLICY REFORM

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **RECOMMENDATIONS ADOPTED AS FOLLOWS**
REMAINDER OF REPORT FILED
See Policy H-95.901

INTRODUCTION

At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 203 entitled, "Drug Policy Reform," was introduced by the Medical Student Section and called on the AMA to:

- Advocate for federal and state reclassification of drug possession offenses as civil infractions and the corresponding reduction of sentences and penalties for individuals currently incarcerated, monitored, or penalized for previous drug-related felonies;
- Support federal and state efforts to expunge criminal records for drug possession upon completion of a sentence or penalty at no cost to the individual; and

- Support federal and state efforts to eliminate incarceration-based penalties for persons under parole, probation, pre-trial, or other criminal supervision for drug possession.

Ultimately, Resolution 203 was referred to the Board of Trustees for study. Some of the primary reasons for referral included the need for more background information on criminal penalties for drug possession; the need to review the role of expungement for those convicted of drug-related crimes for drug possession; and the need to identify the AMA's unique role concerning other issues relating to drug possession. This report also provides background information; discusses relevant policy and public health considerations; presents AMA policy; and makes recommendations.

BACKGROUND

The National Center for Drug Abuse Statistics (NCDAS) reports that, "1.16 million Americans are arrested annually for drug related offenses" and that, "227,655 Americans are arrested annually for the possession of heroin, cocaine, and derivative products." At the same time, NCDAS reports that, "40,446 Americans are arrested annually for the possession of synthetic drugs."[1] A 2022 report from the Pew Charitable Trusts found that between 2009-2019, "87 percent [of] drug arrests were for possession; the rest were for sale or manufacturing."[2] In the federal prison system, more than 44 percent of individuals were incarcerated because of a drug-related offense.[3]

Incarceration rates for drug-related offenses, however, are decreasing. While the figures vary by state, between 2009-2019, "The prison population in the 39 states with available data dropped by approximately 117,000 individuals from 2009 to 2019. The decrease in the number of people in prison for drug offenses accounted for 61% of this total decline. Similarly, prison admissions fell by more than 131,000 from 2009 to 2019, with the drop in drug-related admissions accounting for 38 percent of the total."[4]

There are significant racial disparities for those incarcerated for a drug-related offense. While use and dependence rates between groups only vary by 1-2 percent, Black people are far more likely to be arrested and incarcerated.[5] These disparities have existed for decades,[6] and they unfortunately continue. Research from 2000 showed that Black individuals made up more than 60 percent of those sent to state prisons for a drug-related offense[7]. The same study reported that, "Nationwide, black men are sent to state prison on drug charges at 13 times the rate of white men." More recent data show that, "prison admissions for Black individuals for drug offenses decreased by 59 percent between 2009 and 2019, accounting for a quarter (26 percent) of the total drop in admissions over that span."[8] Despite these decreases, disparities remain. According to the Pew Charitable Trusts, "Black people made up 28 percent of admissions and 36 percent of the population in prison for drug convictions in 2019, which are two and three times, respectively, their share of the general population."

The data also show differences in the prison population when race and gender are both considered. Between 2009-2019, there was a "4 percent increase in admissions of White individuals for drug offenses…[and] a 32 percent increase in the number of White females entering prison with drug convictions. By comparison, admissions for drug offenses fell 71 percent for Black females and 4 percent for White males."[9]

Regarding youth-related drug offenses, between 2011-2020, there were an estimated 42,280 juvenile arrests.[10] Juvenile arrests for drug offenses decreased 72 percent between 2016-2020.[11] According to the U.S. Office of Juvenile Justice and Delinquency Prevention, "the peak year for juvenile drug abuse violation arrest rates was 1997 … [and] overall from 1980 to 2020, the drug abuse violation arrest rate for youth ages 15-17 decreased 64 percent , compared with a 21 percent decrease for young adults ages18-20 and a 7 percent increase for young adults ages 21-24."[12]

Civil Infractions, Misdemeanors, and Felonies

It is beyond the scope of this report to go into extensive detail about the wide variability and extensive nuances in federal or state criminal codes concerning drug possession.[13] A brief overview, however, may be useful to underscore that the AMA's unique role for this report is to focus on public health rather than criminal law.

In general, a misdemeanor means any crime that does not amount to a felony.[14] Misdemeanors generally are those criminal offenses that carry punishments by incarceration of a year or less.[15] A felony typically denotes a crime more serious than a misdemeanor that subjects an individual to incarceration.[16] Punishments for a felony typically are incarceration for periods of one year or more.[17] An "infraction" can have different meanings depending on the

state, but it generally refers to a criminal act that is less serious and carries less severe penalties than a misdemeanor, such a speeding ticket or parking meter violation.[18] Criminal codes also distinguish "simple possession"[19] from possession with intent to sell or distribute.[20]

To prove a statutory crime, it is required to show both that an individual committed a criminal act, and in so doing, acted with the state of mind requisite to constitute the crime in question.[21] For simple drug possession, the prosecutor must prove, generally, that the illicit substance was knowingly and/or intentionally in the accused individual's possession. Simple possession crimes differ from those with intent to sell, manufacture or deliver in that simple possession typically is limited to personal use or control whereas the crime of possession with intent to sell, manufacture or deliver requires proving both possession/control of an illicit substance and that the individual had the intent to sell, manufacture or deliver the substance. To prove intent to sell, manufacture or deliver, additional facts would be required, which could come from undercover law enforcement or other witness testimony, exchange of money, possession of manufacturing equipment, video surveillance, customer lists or other factual elements that show more than just an intent limited to personal use or control.

There are a limited number of states that have decriminalized certain drug-related offenses. In 2020, Oregon voters passed Ballot Measure 110, which among other things, effectively decriminalized possession of certain amounts of Schedule I Controlled Substances, including cocaine, heroin, psilocybin, and methamphetamine. Possession of amounts greater than the law authorized, as well as possession for non-prescribed Schedule II-IV Controlled Substances, would subject an individual to a "Class E" violation. Violators would be subject to a fine or agree to undertake a screening in lieu of a fine.[22] Since the measure went into effect, more than 7,600 individuals have received a Class E violation with methamphetamine (55 percent) and Schedule II Controlled Substances (26 percent) the top reasons for violations.[23] In response to multiple factors, including considerable public concern about reported increases in public drug use, mortality and crime, the Oregon Legislature effectively ended decriminalization of illegal drugs for personal use with passage of House Bill 4002, which the governor said she will sign.[24] HB 4002 passed with wide, bipartisan margins in both the Oregon House and Senate.[25]

Additional state actions have occurred regarding psychedelics and other substances. For example, legislative efforts surrounding Schedule I psychedelics are increasing. More than two dozen states have considered or enacted measures to further study psychedelics, regulate their use, and establish pilot treatment programs. For example, certain psychedelics were decriminalized in Washington, D.C. in 2021[26] and Colorado in 2022.[27] In 2021, drug possession was decriminalized in Washington state as a result of a state supreme court decision in *State v. Blake*, which found the state's drug possession statute unconstitutional because it lacked an intent requirement.[28] The Washington Legislature re-criminalized drug possession (as a misdemeanor) several months later in a special session.[29] The Washington law also included provisions for diversion programs as an alternative to incarceration. The 2024 state legislative sessions are actively considering many similar proposals.[30]

Expungement

The Board of Trustees explained in Board of Trustees Report 17-A-22 that it is important to recognize that expungement, destruction, and sealing are legal processes.[31] An expungement process may involve multiple steps where the result is to remove a record of arrest and/or conviction from the official state or federal record. The idea is that post-expungement, the record never existed. While an expungement may "erase" a record, "sealing" hides the record from public view. More specifically, when "sealed," the record can be accessed under certain circumstances.[32] Finally, "destruction" of a record generally means to physically destroy it. When a record is "destroyed," there is no record remaining whatsoever.[33] It is important to note that specific definitions may vary by state.

Under federal law, the record of a conviction for drug possession may be able to be expunged depending on the circumstances. An individual must qualify for expungement and undertake the process to formally seek expungement. There are different requirements for those 21 years of age and older and those younger than 21. The record of the underlying expungement also offers protection against future adverse use, but it is retained by the U.S. Department of Justice.[34]

At the state level, eligibility, and procedures for expungement of drug possession crimes vary considerably[35]. State laws often are non-specific to controlled substances. In other words, eligibility and procedures would be dependent on multiple factors, including whether a drug possession crime was a misdemeanor or felony, and whether there were additional circumstances, including whether there were other crimes committed and whether they were violent

or nonviolent. Other states have waiting periods after a sentence has been served, but these also are dependent on other factors that may be present, including whether the drug possession crime was a first offense. States typically have different processes and qualifications for minors.[36] In contrast, 24 states have specific procedures when the state has decriminalized cannabis for medical and/or adult use.[37]

DISCUSSION

Reclassification of Drug Possession Offenses as Civil Infractions

Proponents of decriminalizing drug possession cite multiple potential benefits, including saving money from incarceration, focusing resources on treatment and social services, and other benefits such as reducing the stigma surrounding drug use and having a substance use disorder.[38] Being incarcerated does not often lead to treatment for a substance use disorder. The Pew Charitable Trusts reported data showing that "1.1 million people with past-year illicit drug dependence or misuse reported being arrested and booked in the past year…[but] 1 in 13—85,199—reported receiving drug treatment while in jail or prison. Further, the drug- or alcohol-related mortality rate in jails increased from 9 in 100,000 in 2009 to 26 in 100,000 in 2019."[39] Proponents also point to collateral consequences of having a criminal record for drug possession, including denial of public benefits, losing custody of children, loss of voting rights, inability to secure loans or financial aid, to name a few negative effects.[40] A meta-analysis of drug decriminalization policies in 2020 focused on "evaluating effects of drug decriminalization or legal regulation on drug availability, use or related health and social harms globally."[41] The analysis concluded there was "a need for a broadening of the metrics used to assess the impacts of drug decriminalization and legal regulation."

Except for cannabis, there are few tangible examples in the United States on which to evaluate the potential public health and collateral benefits of reclassifying drug possession offenses as civil infractions. The Board of Trustees notes that our AMA Council on Science and Public Health has issued two previous reports detailing the continued public health dangers associated with cannabis. Oregon, Colorado, and Washington, D.C. are the only states to specifically decriminalize illicit substances, while multiple others have enacted measures to direct law enforcement to treat possession of, for example, certain psychedelics, as a "low priority."[42] In Oregon, the language of Ballot Measure 110 based part of its argument on the premise that, "People suffering from addiction are more effectively treated with health care services than with criminal punishments. A health care approach includes a health assessment to figure out the needs of people who are suffering from addiction, and it includes connecting them to the services they need." The reality of Ballot Measure 110's effects, however, demonstrate widespread challenges with connecting individuals to screening, treatment, or recovery.

Three main studies of the effects of Oregon Ballot Measure 110 show that it generally failed to reduce overdose-related fatality, and that it did not connect individuals to screening, treatment, or recovery. One study found that Ballot Measure 110 "caused 182 additional unintentional drug overdose deaths to occur in Oregon in 2021. This represents a 23 percent increase over the number of unintentional drug overdose deaths predicted if Oregon had not decriminalized drugs."[43] A separate study, however, found that there was no significant change in death rates.[44] Perhaps most concerning is that Ballot Measure 110's promise of increased connections to treatment and increased access to evidence-based care has not been realized. A state audit of Ballot Measure 110 discussed the widespread hopes for the ballot measure to improve access to care for substance use disorders, reduce health inequities, and other laudable goals. The reality, unfortunately, has been hampered by widespread challenges, including inefficient "program governance," "silos and fragmentation in the delivery of mental health and substance use disorder treatment," poor "stakeholder collaboration," poor data collection and reporting structures, and a lack of coordination between public health, public safety, and other agencies.[45]

The Board of Trustees understands that the original intent of Oregon Ballot Measure 110 included an effort to increase access to treatment, but there is a clear lack of evidence demonstrating public health benefits or increases in access to evidence-based mental health or substance use disorder services in the state. The available research, furthermore, does not clearly demonstrate tangible benefits on a wider scale. The Board of Trustees observes that drug-related overdoses in Oregon have increased from 1,147 deaths reported for the 12-month period between October 2020 and October 2021 to 1,683 deaths reported for the 12-month period between October 2022 and October 2023.[46] The Board of Trustees believes that it is premature to recommend decriminalizing drug possession offenses as a public health benefit in the absence of evidence demonstrating public health benefits.

Expungement of Criminal Records for Drug Possession upon Completion of a Sentence

As noted above, there are ongoing collateral consequences experienced by individuals convicted of drug possession (or other) crimes. The Board of Trustees emphasized these consequences as part of Board of Trustees Report 17-A-22, "Expungement, Destruction, And Sealing Of Criminal Records For Legal Offenses Related To Cannabis Use Or Possession." That report recommended support for expungement of cannabis-related offenses when those offenses were no longer illegal (because of newly enacted state laws). As the Board stated in BOT Report 17-A-22,

> Even if a record is expunged or sealed, however, that may not address collateral consequences of the arrest or conviction, e.g., potential professional licensing sanctions, adverse employment actions, and qualification for government benefits, including loans and housing. These collateral consequences can also suppress the local tax base by locking people into unemployment or lower paying jobs and increase taxpayer costs due to increasing likelihood of further involvement in the criminal legal system.[47]

The Board of Trustees supports reducing barriers to address these social determinants of health, including supporting federal and state efforts to expunge criminal records for drug possession upon completion of a sentence or penalty. Given that individuals released from jail or prison may have limited financial means, we also support that the expungement process consider an individual's financial hardship.

Incarceration-based Penalties for Persons under Parole, Probation, Pre-trial, or other Criminal Supervision for Drug Possession.

As with different state laws and policies concerning what constitutes a drug possession felony or misdemeanor, there is likely even greater state variation in what constitutes a violation of parole, probation, pre-trial, or other supervisory agreement with an individual charged or convicted of drug possession. While drug possession while on parole might trigger an automatic revocation in some jurisdictions, in others there would be discretion. This is why some commentators argue for the "need to critically examine the revocation process for probationers and parolees who transgress the terms and conditions of their community supervision."[48] Other commentators cite drug use or drug possession as a common reason for parole, probation or other supervisory violations.[49] The Board of Trustees notes that AMA advocacy and policy focus primarily on helping ensure individuals involved with the justice system have access to evidence-based care. We certainly encourage discretion by court officers but do not believe that the AMA has the unique expertise or experience to make categorical determinations about judicial discretion.

Your Board – in a separate board report under consideration at this meeting, Board of Trustees Report 16 – explains why diversion programs should not automatically exclude individuals because they may have previously used illicit substances. Similarly, we argue that individuals should not be removed from a diversion program solely because they used an illicit substance. The National Institute of Drug Abuse explains that "The chronic nature of addiction means that for some people relapse, or a return to drug use after an attempt to stop, can be part of the process, but newer treatments are designed to help with relapse prevention. Relapse rates for drug use are similar to rates for other chronic medical illnesses. If people stop following their medical treatment plan, they are likely to relapse."[50] AMA support for individuals being able to continue parole or probation even if they engaged in illegal drug use is a natural extension of AMA policy to not punish people because they have a substance use disorder.

AMA POLICY

AMA policy includes "support [for] legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes." (Policy H-80-993, "Ending Money Bail to Decrease Burden on Lower Income Communities"). AMA policy also supports a broad range of elements for individuals who are incarcerated, including, "…(a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing." (Policy H-430-986, "Health Care While Incarcerated"). Whether

these elements could be achieved through decriminalization of drug possession crimes is not clear, however, which is why your Board supports additional research to inform future decision making.

AMA policy also supports "automatic expungement, sealing, and similar efforts regarding an arrest or conviction for a cannabis-related offense for use or possession that would be legal or decriminalized under subsequent state legalization or decriminalization of adult use or medicinal cannabis." (Policy H-95.910, "Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession"). AMA's cannabis-related expungement policy also extends to protections for minors and for "ending conditions such as parole, probation, or other court-required supervision because of a cannabis-related offense for use or possession that would be legal or decriminalized under subsequent state legalization or decriminalization of adult use or medicinal cannabis." (Policy H-430.986, "Health Care While Incarcerated"). Finally, AMA policy also calls for "fairness in the expungement and sealing of records." (Policy H-60.916, "Youth Incarceration in Adult Facilities"). These policies highlight issues of fairness with respect to expungement as well as support for the principle that drug use or possession—by itself—should not be a cause for additional criminal penalty.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 203 and the remainder of the report be filed:

1. That our American Medical Association (AMA) support elimination of criminal penalties for drug possession for personal use as part of a larger set of related public health and legal reforms designed to improve carefully selected outcomes;
2. That the AMA will support federal and state efforts to automatically expunge, at no cost to the individual, criminal records for drug possession for personal use upon completion of a sentence or penalty; and
3. That the AMA support programs that provide comprehensive substance use disorder treatment and social support to people who use or possess illicit drugs for personal use as an alternative to incarceration-based penalties including for persons under parole, probation, pre-trial, or other civic, criminal, or judicial supervision.
4. Concurrently, that our AMA support robust policies and funding that facilitate people's access to evidence-based prevention, early intervention, treatment, harm reduction, and other supportive services – with an emphasis on youth and racially and ethnically minoritized people – based on individualized needs and with availability in all communities.

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18. SUPPORTING HARM REDUCTION

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 204-A-23 REMAINDER OF REPORT FILED**
See Policies D-95.987 and H-95.900

INTRODUCTION

At the June 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD), Resolution 204 entitled, “Supporting Harm Reduction,” was introduced by the Medical Student Section and called on the AMA to:

- Advocate for the removal of buprenorphine from the misdemeanor crime of possession of a narcotic;

- Support any efforts to decriminalize the possession of non-prescribed buprenorphine; and
- Amend the 4th and 6th resolves of Policy D-95.987 by addition and deletion to read as follows:
  4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of "drug paraphernalia" designed for harm reduction from drug use, including but not limited to drug contamination testing, safer smoking, and injection drug preparation, use and disposal supplies.

  6. Our AMA will advocate for ~~supports efforts to~~ increased access to and decriminalization of fentanyl test strip, ~~and~~ other drug checking supplies, and safer smoking kits for purposes of harm reduction.

The HOD discussed the strong evidence base supporting buprenorphine as a treatment for opioid use disorder (OUD), the uncertainty surrounding the facts of buprenorphine "diversion," and the significant concerns about the meaning and practice of "safer smoking." Ultimately, the HOD referred the resolution to the Board of Trustees for study. In response, this board report provides background information; discusses the different issues raised by the resolution; presents AMA policy; and makes policy recommendations.

BACKGROUND

Buprenorphine

Buprenorphine is a Schedule III Controlled Substance that the U.S. Drug Enforcement Administration (DEA) defines as a narcotic for purposes of drug scheduling.[1] The U.S. Food and Drug Administration (FDA) first approved buprenorphine-containing products in 2002 for the treatment of OUD. Buprenorphine for OUD may be prescribed as a "mono-product," and some manufacturers combine it with naloxone ("combination product") to treat OUD. It may be available as a tablet, sublingual film, transdermal film, or injection.

There is widespread evidence that supports buprenorphine as an evidence-based medication to treat OUD.[2] Researchers and clinicians commonly promote statements such as, "opioid agonist therapy (OAT) with methadone or buprenorphine is the gold-standard treatment for OUD."[3] The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) provides multiple resources about buprenorphine, including clinical and safety information, treating pregnant and postpartum individuals, potential for misuse, and safety considerations.[4] Because of its evidence-base, AMA advocacy has for years called for removing all barriers to buprenorphine for the treatment of OUD—including prior authorization reforms,[5] the x-waiver,[6] telehealth restrictions,[7] and dosage caps.[8]

While prescriptions dispensed for medications to treat opioid use disorder (MOUD) have marginally increased in the past five years from 14.54 million to 16.05 million,[9] there remain millions of Americans who misuse illicit substances, prescription opioids and/or have untreated substance use disorder.[10] More than 78 million illicit fentanyl-containing pills and 12,000 pounds of fentanyl powder were seized by the U.S. Drug Enforcement Administration (DEA) in 2023.[11] The U.S. Centers for Disease Control and Prevention (CDC) advise that, "Powdered fentanyl looks just like many other drugs. It is commonly mixed with drugs like heroin, cocaine, and methamphetamine and made into pills that are made to resemble other prescription opioids."[12]

"Safer Smoking"

As a threshold matter, and discussed briefly below, the AMA does not support the concept of "safer smoking." The issue of "safer smoking" in relation to the nation's drug-related overdose and death epidemic, however, is a harm reduction concept that seeks to reduce the spread of infectious disease as well as support changes to injection drug use. The types of safer smoking supplies are often, "specific for each type of drug used, but generally includes a heat resistant pipe or foil, protective mouthpiece, tamp, screen, and lip protectant, all of which reduce heat-related injuries and infection risk."[13] In addition to reducing injection drug use, proponents of safer smoking supplies also point to, "Smoking supplies distributed by harm reduction programs [that] are clean and safer than improvised items like aluminum cans, plastic tubes, steel wool, and light bulbs that can break easily or release toxic fumes."[14] These supplies are typically considered illicit drug paraphernalia, and "Nearly all states penalize the possession and distribution of glass pipes and other devices used for smoking or inhaling illegal drugs."[15]

In addition to state law prohibitions against safer smoking supplies, federal law defines a wide variety of materials as illegal drug paraphernalia, including,

> (1) metal, wooden, acrylic, glass, stone, plastic, or ceramic pipes with or without screens, permanent screens, hashish heads, or punctured metal bowls; (2) water pipes; (3) carburetion tubes and devices; (4) smoking and carburetion masks; (5) roach clips: meaning objects used to hold burning material, such as a marihuana cigarette, that has become too small or too short to be held in the hand; (6) miniature spoons with level capacities of one-tenth cubic centimeter or less; (7) chamber pipes; (8) carburetor pipes; (9) electric pipes; (10) air-driven pipes; (11) chillums; (12) bongs; (13) ice pipes or chillers; (14) wired cigarette papers; or (15) cocaine freebase kits.[16]

Every state—except Alaska—has a drug paraphernalia law.[17] While state laws vary considerably, one distinction is that needles and syringes may still be considered drug paraphernalia, but they are allowed for personal use in most states. Penalties for individuals convicted of possession or use of other drug paraphernalia can range from misdemeanors to felonies.[18]

DISCUSSION

Decriminalization of Non-prescribed Possession and Use of Buprenorphine

While penalties vary, possession of non-prescribed buprenorphine—like other non-prescribed controlled substances—is generally considered a violation of state and/or federal law and can subject an individual to monetary penalties and/or imprisonment depending on the circumstances.[19] One of the key questions for this board report, however, is whether the benefits of using non-prescribed buprenorphine in certain circumstances outweigh the risks. The National Institute on Drug Abuse (NIDA) reports that, "most data suggest that the majority of buprenorphine and methadone misuse (use without a prescription) is for the purpose of controlling withdrawal and cravings for other opioids and not to get high."[20] NIDA also points out low rates of diversion risk, illicit use, and emergency department visits related to buprenorphine. Research comparing buprenorphine-involved deaths compared to opioid-involved deaths during the COVID-19 pandemic found that, "actions to facilitate access to buprenorphine-based treatment for opioid use disorder during the COVID-19 pandemic were not associated with an increased proportion of overdose deaths involving buprenorphine; efforts are needed to expand more equitable and culturally competent access to and provision of buprenorphine-based treatment."[21] The AMA has argued that individuals' lack of access to buprenorphine is due to multiple factors, including stigma, and inadequate networks of addiction medicine physicians, psychiatrists, primary care and other physicians willing to prescribe buprenorphine. Access to buprenorphine is particularly problematic for racial and ethnic minorities.[22] The AMA and the AMA Substance Use and Pain Care Task Force has long urged that all efforts be taken to increase access to buprenorphine and other medications for opioid use disorder (MOUD). Decriminalization, however, is an issue of first impression for the AMA.

Decriminalization of possession of non-prescribed buprenorphine for personal use already is occurring in the United States. Vermont became the first state in 2021 to specifically decriminalize possession of 224 milligrams of non-prescribed buprenorphine for personal use.[23] Initially enacted as a two-year pilot, after positive reviews that the bill helped increase access to buprenorphine among people who use drugs (PWUD) and also increase access to other forms of treatment, the Vermont Legislature made the exemption permanent in 2023.[24] Rhode Island also decriminalized buprenorphine in 2021 by amending its criminal code.[25] Another state example is when Oregon, in 2020, effectively decriminalized a wide range of drugs for personal use, including Schedule III Controlled Substances.[26] It is not clear whether this has increased access to buprenorphine in Oregon, but a report from the Oregon Judicial Department did not cite "buprenorphine" for any of the new "Class E" violations.[27]

Multiple studies have found the mortality risk of buprenorphine is low. This includes retrospective mortality reviews showing how buprenorphine-involved mortality was commonly part of polysubstance use.[28] In a study of Medicare beneficiaries, "Buprenorphine treatment after nonfatal opioid-involved overdose was associated with a 62% reduction in the risk of opioid-involved overdose death."[29] A review of COVID-19-era opioid-involved overdose deaths found that "buprenorphine was involved in 2.6 percent of opioid-involved overdose deaths during July 2019 to June 2021"—a rate that "did not increase" even as rates of overdose overall increased.[30] Commentators suggest that while there are some risks to using non-prescribed buprenorphine, there are many benefits, including overcoming barriers that, "extend across socioeconomic, bureaucratic, and stigmatizing lines and include unemployment, insurance status, buprenorphine waiting lists, and most importantly, knowledge and physical access

to providers who can and want to prescribe buprenorphine."[31] The Board of Trustees acknowledges that use of nonprescribed buprenorphine carries risks, but views the available evidence as mitigating in support of doing all that is necessary to reduce health inequities and save lives from an opioid-related overdose, including decriminalizing the personal possession and use of nonprescribed buprenorphine.

"Safer Smoking" as a Harm Reduction Measure

The AMA has supported a broad range of what are generally considered "harm reduction" measures. This includes support for laws and other policies encouraging prescribing, distribution, and use of naloxone and other opioid-overdose reversal agents. The AMA also supports broad Good Samaritan protections to provide civil and criminal protections for individuals at the scene of an overdose event. The AMA further supports the same protections for individuals who overdose. AMA policy also supports harm reduction centers (also called overdose prevention sites), as well as the ability for syringe services programs (SSPs) to provide sterile needles and syringes to help stem the spread of blood borne infectious disease. While there will always be detractors and stigma, these harm reduction measures have been well-studied and have been shown to help reduce mortality and improve health outcomes. It is beyond the scope of this report to detail all the research for these measures, but it is important to highlight that each (to different degrees) has largely overcome stigma in the medical community. The Board of Trustees acknowledges that sigma remains a considerable barrier for SSPs and harm reduction centers.

Injection drug use continues to be a major public health issue. A Centers for Disease Control and Prevention (CDC) study found that nearly 3.7 million people in the United States injected drugs in 2018—a 5-fold increase from 2011.[32] The study also found that more than 42 percent of overdose deaths were from injections. Another CDC report found that, "During 2013–2017, reported methamphetamine, injection drug, and heroin use increased substantially among women and heterosexual men with [primary and secondary] syphilis."[33] Injection drug use may also result in the spread of skin and groin infections, Hepatitis C, bacterial endocarditis, osteomyelitis, and other preventable health conditions.[34] Prevention of the spread of blood-borne infectious disease is one of many reasons the AMA strongly supports broad access to sterile needle and SSPs.

AMA support for SSPs, however, has been based on the strong evidence-base for SSPs. We raise the question, therefore, whether the evidence supports increased use of safer smoking supplies (as defined above), including decriminalization of such supplies. A 2023 descriptive review of 550 PWUDs found that there was limited access but high interest in obtaining safer smoking supplies for heroin, crack cocaine, and methamphetamine.[35] The authors were clear about the study limitations but highlighted other research suggesting that obtaining safer smoking supplies could reduce injection drug use. A recently published meta-review of global practices reported that, "Ten studies found that when people who use drugs were provided with safer smoking materials, they engaged in fewer risky drug use behaviors (e.g., pipe sharing, using broken pipes) and showed improved health outcomes."[36] The authors concluded that, "safer smoking practices are essential forms of harm reduction," but that "Additional research is also needed to evaluate the efficacy of and access to safer smoking services, particularly in the U.S. and other similar countries, where such practices are being implemented but have not been empirically studied in the literature." We agree that more research is necessary.

It is also important to emphasize that additional research into the potential benefits of any harm reduction measure in no way condones or supports the use of illicit drugs or other substances whether through injection, inhalation, or other routes of administration. The Board of Trustees notes that while reductions in injection drug use should be considered positive, it is deeply concerning that it may be accompanied by increases in smoking illicit fentanyl.[37] We agree with comments from addiction psychiatrists such as, "I do not know that we are at a place where we can say, 'Hey, maybe you should smoke it instead,'" and "It would be hard for me to feel confident in recommending that to somebody."[38] Further, it must be stressed that there is no such thing as "safer smoking" of fentanyl, cannabis, tobacco or illicit substances, and also stressed that smoking fentanyl carries significant risks, including overdose and death.[39] Similarly, the Board of Trustees believes that while there may be some evidence showing reduced harms associated with smoking fentanyl and certain safer smoking supplies as compared to injection use, there is a clear need for much more research before the AMA spends it resources and puts its public health and science credibility on the line.

Decriminalization of Fentanyl Test Strips

This resolution also calls for the AMA to support the decriminalization of fentanyl test strips. It is critical to note that this ask is redundant as AMA policy already effectively accomplishes this. Specifically, our policy states that,

"Our AMA will: advocate for the removal of fentanyl test strips (FTS) and other testing strips, devices or testing equipment used in identifying or analyzing whether a substance contains fentanyl or other adulterants from the legal definition of drug paraphernalia." (Policy D-95.987, "Prevention of Drug-Related Overdose") The AMA has advocated for this at the state and federal levels[40] and encourages all medical societies to support legislation to implement this important policy. In this regard, we appreciate the opportunity to highlight AMA advocacy and conclude that existing policy (and subsequent advocacy measures) already meet the intent and purpose of the resolution.

AMA POLICY

Extending AMA policy to support decriminalization of non-prescribed buprenorphine for personal use would become part of a broad and growing policy base supporting increased access to buprenorphine and other MOUD. Policies in this family include:

- Policy H-420.970, "Treatment Versus Criminalization - Physician Role in Drug Addiction During Pregnancy;"
- Policy H-95.956, "Harm Reduction Through Addiction Treatment;"
- Policy H-430.987, "Medications for Opioid Use Disorder in Correctional Facilities;"
- Policy H-290.962, "Medicaid Substance Use Disorder Coverage;"
- Policy H-320.941, "Eliminate Fail First Policy in Addiction Treatment;"
- Policy H-95.944, "Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy;"
- Policy D-95.955, "Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD);" and
- Policy D-95.972, "Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder."

It bears repeating that the Board of Trustees strongly supports the provision of MOUD to occur within a medically supervised and physician-led environment. We also recognize that given the innumerable barriers to such care, combined with the clear benefits of increasing access to buprenorphine, calling for decriminalization of non-prescribed buprenorphine for personal use is necessary to help reduce harms, including overdose and death.

AMA policy already supports efforts to increase access to a broad range of harm reduction initiatives:

> Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of "drug paraphernalia" designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies. (Policy D-95.987, "Prevention of Drug-Related Overdose")

It is reasonable to conclude, therefore, that this policy helps inform AMA support for SSPs, public availability of sharps disposal units, and other areas. For example, AMA support for SSPs can be found here:

> . . . encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. strongly supports the ability of physicians to prescribe syringes and needles to patients who inject drugs in conjunction with addiction counseling to help prevent the transmission of contagious diseases. (Policy H-95.954, "The Reduction of Medical and Public Health Consequences of Drug Use")

Finally, as discussed above, the evidence base for SSPs has been demonstrated. In contrast, the evidence base in support of safer smoking supplies has not. The Board, therefore, urges increased research as it relates to the latter.

RECOMMENDATIONS

The Board of Trustees recommends that the following new policy be adopted in lieu of Resolution 204, and that the remainder of the report be filed.

1. That the American Medical Association (AMA) support efforts to decriminalize the possession of non-prescribed buprenorphine for personal use by individuals who lack access to a physician for the treatment of opioid use disorder;
2. That the AMA support decriminalization of harm reduction supplies that reduce the likelihood of injection drug use and mitigate health risks of all types of drug use, including injection drug use and smoking.
3. That the AMA encourage additional study whether "safer smoking supplies" may be a potential harm reduction measure to reduce harms from the nation's overdose and death epidemic; and
4. That the AMA reaffirm Policy D-95.987, "Prevention of Drug-Related Overdose."

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19. ATTORNEYS' RETENTION OF CONFIDENTIAL MEDICAL RECORDS AND CONTROLLED MEDICAL EXPERT'S TAX RETURNS AFTER CASE ADJUDICATION

Reference committee hearing; see report of Reference Committee B.

HOD ACTION: **RECOMMENDATIONS ADOPTED**
IN LIEU OF RESOLUTION 240-A-23
REMAINDER OF REPORT FILED
See Policy D-265.987

INTRODUCTION

Resolution 240-A-23, introduced by the Illinois State Medical Society, consisted of the following proposals:

> RESOLVED, That our American Medical Association advocate that attorney requests for controlled medical expert personal tax returns should be limited to 1099-MISC forms (miscellaneous income) and that entire personal tax returns (including spouse's) should not be forced by the court to be disclosed (Directive to Take Action); and be it further
>
> 3.
>
> RESOLVED, That our AMA advocate through legislative or other relevant means the proper destruction by attorneys of medical records (as suggested by *Haage v. Zavala*, 2021 IL 125918)[1] and medical expert's personal tax returns within sixty days of the close of the case. (Directive to Take Action).

FIRST RESOLVED

In cases requiring physicians as medical expert witnesses, their testimony is critical to the resolution of the case. They provide an invaluable service. At the same time, it is the right of the opposing party's attorney to request discovery that allows the attorney to cross-examine the witness to show potential bias. *See United States v. Abel*, 469 U.S. 45, 49-52 (1984). This discovery often involves the expert's financial history. Still, discovery must be balanced with the expert's privacy rights and the burden imposed. *See Grant v. Rancour*, 157 N.E.3d 1083, 1094-95 (Ill. 2020). ("[W]hile cross-examination is permissible to show bias, partisanship, or financial interest, there is a point at which such inquiries trample on the legitimate bounds of cross-examination and unduly harass or unnecessarily invade the privacy of the witness.").

[1] The form of citation quoted in the First Resolved refers to an Illinois-specific publication, one that might not be available to those outside of Illinois. For ease of reference and accessibility, the Board will use the citation of the case as published in the North Eastern Reporter, a widely available publication. The citation is *Haage v. Zavala*, 183 N.E.3d 830 (Ill. 2021).

There is no general rule or universal leaning that courts take when it comes to an expert's personal tax returns. Personal tax returns may be relevant to show an expert's potential biases – how often they have testified, how much they have earned for that testimony, what sources are paying for that testimony, etc. Courts decide whether personal tax returns should be allowable discovery on a case-by-case basis, depending on the specific facts of the case. *See, e.g.*, *Olson v. State Farm Fire & Cas. Co*., No. C14-0786RSM, 2015 WL 753501, at *3 (W.D. Wash. Feb. 23, 2015) ("there is no need for the expert to have to produce his or her tax returns, if the party seeking the discovery has accurate information regarding the percentage of income earned as an expert"); *but see Noffke v. Perez*, 178 P.3d 1141, 1150 (Alaska 2008) ("trial court determined that the income tax returns were relevant and that production of the returns would help clarify any stake the witness might have in the outcome of the case"). As with most discovery disputes, the resolution is within the court's discretion. "Courts must use their discretion to oversee the process and ensure that it is fair to both sides." *Grant*, 157 N.E.3d at 1095.

With this background, the Board agrees that seeking a medical expert's entire personal income tax returns is, in most instances, overly broad and unnecessarily invades the expert's privacy. The Board also agrees that limiting personal tax return discovery of a medical expert to miscellaneous income (1099-MISC forms) strikes a reasonable balance between allowing the probing for potential bias and protecting the expert's privacy and burdens. Miscellaneous income discovery would encompass the income that is received from serving as an expert, and the source of that income. In most cases, this should shed sufficient light on potential bias.

This position is also in line with current AMA policy, which states, "(c) The AMA supports the right to cross examine physician expert witnesses on the following issues: (i) the amount of compensation received for the expert's consultation and testimony; (ii) the frequency of the physician's expert witness activities; (iii) the proportion of the physician's professional time devoted to and income derived from such activities; and (iv) the frequency with which he or she testified for either plaintiffs or defendants." *Expert Witness Testimony*, H-265.994.

On the other hand, the Board believes the phrase "and that entire personal tax returns (including spouse's) should not be forced by the court to be disclosed" should be removed from the First Resolved. It would be an overreach for the AMA to tell courts how to use their discretion in managing discovery, which as discussed, varies on a case-by-case basis. In any event, the first part of the Resolved makes this latter part largely unnecessary. Advocating for the limitation of tax return discovery to miscellaneous income means that the discovery of entire personal tax returns is generally unnecessary and inappropriate. Along those lines, we suggest that the word "usually" be inserted between "should" and "be."

As such, the Board believes the First Resolved should be rewritten as follows:

> RESOLVED, That our American Medical Association advocate that attorneys' discovery requests for the personal tax returns of a medical expert for the opposing party should usually be limited to 1099-MISC forms (miscellaneous income).

SECOND RESOLVED

The Second Resolved likely lumps together two different categories of documents: 1) client medical records, and 2) tax returns of medical experts. The first category is personal health information ("PHI"), likely protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The second category is financial information that has nothing to do with HIPAA. Yet the Second Resolved advocates for the destruction of both types of documents within 60 days of the conclusion of a case, using *Haage v. Zavala*, 183 N.E.3d 830 (Ill. 2021) as an example.

In *Haage*, a personal injury matter, the trial court issued HIPAA qualified protective orders ("QPOs") expressly requiring the destruction of PHI within 60 days after the conclusion of the litigation. The insurance company objected to the QPOs, arguing that the orders prevented insurers from performing functions related to fraud detection and deterrence. The appellate court disagreed and enforced the QPOs, finding that no law or regulations required the insurance company to use or disclose plaintiffs' PHI after the conclusion of the litigation. *See Haage*, 183 N.E.3d at 853.

Thus, *Haage* may be relevant to the return or destruction of PHI under a HIPAA QPO, but it is irrelevant to the return or destruction of an expert's tax return information. Thus, the Second Resolved does not need to mention *Haage*.

Regarding the return of client records, the American Bar Association's ("ABA") Rules of Professional Conduct state: "Upon termination of representation, a lawyer shall take steps to the extent reasonably practicable to protect a client's interests, such as . . . surrendering papers and property to which the client is entitled[.] The lawyer may retain papers relating to the client to the extent permitted by other law." ABA Rule 1.6(d). The ABA rules do not address exactly *when* attorneys are to return or destroy their client's records.

As a general matter, the Board agrees with the intent of the Second Resolved – that certain documents contain clients' or experts' sensitive and confidential information, and it is logical that those individuals do not want that sensitive information used or available for longer than absolutely necessary. Sixty days after the conclusion of litigation also seems like a reasonable time period for the return or destruction of those documents. At the same time, the Board notes that reaching this goal will likely be an uphill battle, as it would likely entail specific changes to the ABA's Model Rules of Professional Conduct, and could require changes to state and federal laws. Nonetheless, advocating for this goal seems like a worthwhile effort.

As such, the Board believes the Second Resolved should be rewritten as follows:

> RESOLVED, That our AMA support through legislative or other relevant means the proper return or destruction of client medical records and medical expert's personal tax returns by attorneys within sixty days of the conclusion of the litigation.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 240-A-23 and the remainder of this report be filed:

1. That our American Medical Association advocate that attorneys' discovery requests for the personal tax returns of a medical expert for the opposing party should usually be limited to 1099-MISC forms (miscellaneous income); and
2. RESOLVED, That our AMA support through legislative or other relevant means the proper return or destruction of client medical records and medical expert's personal tax returns by attorneys within sixty days of the conclusion of the litigation.

20. CRIMINALIZATION OF PROVIDING MEDICAL CARE

Informational report; no reference committee hearing.

HOD ACTION: FILED

At the 2023 Annual Meeting of the House of Delegates (HOD), the HOD adopted Resolution 015 -A-23 entitled, "Report Regarding the Criminalization of Providing Medical Care," which instructed the American Medical Association (AMA) to:

> [S]tudy the changing environment in which some medical practices have been criminalized including the degree to which such criminalization is based or not based upon valid scientific findings, the degree to which this is altering the actual practice of medicine due to physician concerns and personal risk assessment, and the degree to which hospitals and health care systems are responding to this rapidly changing environment, with report back to the HOD no later than the November 2023 Interim meeting.

This report is submitted for the information of the HOD.

BACKGROUND

Abortion

On June 24, 2022, the U.S. Supreme Court issued its landmark decision in *Dobbs v. Jackson Women's Health Organization*, holding that the U.S. Constitution does not confer a constitutional right to abortion and returned the authority to regulate abortion to the states. As of the writing of this report in March 2024, 14 states (Alabama,

Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia) prohibit the provision of nearly all abortions, two states (Georgia and South Carolina) prohibit abortion after fetal cardiac activity is detected around six weeks of pregnancy, and nine states (Arizona, Florida, Iowa, Kansas, Nebraska, North Carolina, Ohio, Utah, and Wisconsin) prohibit abortion later in pregnancy, but before the point at which a fetus is generally considered viable. Many of those latter nine states have passed laws prohibiting abortion earlier in pregnancy that have been blocked in court. Importantly, the status of state abortion laws is fluid. Legal challenges are ongoing in nearly two dozen states and the legality of abortion in those states is subject to change.

At the time the *Dobbs* decision was published, 13 states had abortion prohibitions that predated the *Roe v. Wade* decision or so-called "trigger laws" that became effective upon the overruling of *Roe*, including several that were enacted in 2022 just prior to the *Dobbs* decision. In August 2022, the Indiana legislature became the first in the country to pass a post-*Dobbs* abortion ban. West Virginia followed in September 2022, and in 2023, seven states enacted new abortion bans. North Dakota and Wyoming enacted near-total bans; Florida, Iowa, and South Carolina enacted six-week bans; and Nebraska and North Carolina enacted 12-week bans. Not all the newly enacted laws are in effect.

Some, but not all, state abortion bans are punishable with criminal penalties. In other states, violations are subject to professional discipline up to mandatory revocation of the health care professional's license. Some also authorize civil enforcement of abortion bans by private citizens, though courts have declined to authorize those suits.

Each state abortion ban contains an exception or affirmative defense, under specified conditions, when abortion is necessary to preserve the life of pregnant women and other pregnant patients. Most, but not all of the states' laws, also contain exceptions or affirmative defenses when abortion is necessary to prevent serious health consequences (e.g., "serious and irreversible impairment of a major bodily function"). Some laws also contain exceptions or affirmative defenses in cases where the pregnancy was due to rape or incest or when the fetus is diagnosed with a serious condition incompatible with life.

These exceptions, however, are not crafted in a way that aligns with the complexity of medical practice and have led to significant confusion about how to practice medicine when pregnancy complications arise. As a result, physicians report significant uncertainty in navigating the new restrictions and describe a chilling effect on the practice of medicine that extends beyond obstetrics and gynecology into a range of specialties including emergency medicine, oncology, rheumatology, cardiology, psychiatry, and others. The AMA is not aware of data that can reliably quantify the degree to which medical practice has been altered in response to abortion restrictions but understands the impact on physicians, their practice, and their patients to be immense. Media reports have profiled numerous patients who describe harrowing experiences in which they suffered preventable medical complications because legal restrictions prevented medical professionals from providing recommended treatment. Similarly, in a lawsuit seeking to clarify the scope of Texas' medical emergency exception, 22 women describe being denied medically necessary and potentially lifesaving treatment when they were experiencing medical emergencies during their pregnancies.[1] To better track these cases, researchers at the University of California in San Francisco have undertaken a study, *"The Care Post-Roe Study,"* to collect stories from clinicians about how abortion laws have altered the usual standard of care. In May 2023, preliminary findings described 50 cases in which abortion laws resulted in delays, worsened health outcomes, and increased the cost and logistic complexity of care.[2] Additionally, qualitative research published in January 2024 reported on obstetrician-gynecologists' perceived impacts of abortion bans.[3] The 54 research participants described delays in medical care, institutional restrictions on referrals and patient counseling, and inability to provide appropriate medical care. The research also reported high rates of moral distress and other personal impacts among the participants.

Risk-averse hospitals and institutional policies are also likely to contribute to changes in medical practice. In May 2023, the Centers for Medicare & Medicaid Services announced investigations into two Missouri hospitals that allegedly withheld necessary stabilizing care to a pregnant patient experiencing preterm premature rupture of membranes in violation of the Emergency Medical Treatment and Labor Act.[4] The government's announcement stated that, in one situation, although the patient's doctors advised her that her pregnancy was no longer viable and her condition could rapidly deteriorate, they could not provide her with the care that would prevent infection, hemorrhage, and potentially death due to hospital policies. Physicians have described other similar hospital policies in which non-clinicians determine whether and at what point abortion care may be provided.

Though abortion bans may be altering the treatment of pregnancy complications, available data indicate that abortion bans have not reduced the total number of abortions provided but have shifted the geographic distribution of abortion care. The #WeCount initiative led by the Society for Family Planning reported that from July 2022 to June 2023 the number of clinician-provided abortions increased modestly, with a monthly average of 82,115 abortions before the *Dobbs* decision and a monthly average of 82,298 in the 12 months after the *Dobbs* decision.[5] As anticipated, states with abortion bans reported significant declines in the number of abortions provided after *Dobbs*, with 14 states experiencing a 100 percent decrease. Accordingly, the number of live births has risen in places that ban abortion. Research published in November 2024 estimated that, in the first six months of 2023, births rose by an average of 2.3 percent in ban states compared to states where abortion remained legal.[6] The authors estimated that roughly one-fifth to one-fourth of people seeking abortions did not receive them due to bans. Another study from the Johns Hopkins Bloomberg School of Public Health estimated that nearly 9,800 additional live births occurred in Texas in the year after the state's abortion ban took effect.[7]

Conversely, health care professionals in states that do not severely restrict access to abortion have reported an increase in demand for abortion care from out-of-state patients, as well as greater complexity of cases and abortion care, sought later in pregnancy. The #WeCount initiative reported in October 2023 that the increase in abortions provided in these states was greater than the decrease of abortion provided in restrictive states and notes that much of the increase has been in states that border restrictive states.

Abortion bans are also likely to impact the physician workforce. Though data is not available, there have been anecdotal reports of individual physicians opting to leave states with restrictive laws. Similarly, two hospitals in Idaho closed their labor and delivery units, citing difficulties in recruiting staff and the hostile legal environment.[8] The American Association of Medical Colleges (AAMC) also reported that obstetrics and gynecology residency applications declined significantly in states that have banned abortion.[9] AAMC posits that restrictive abortion laws may deter applicants from applying to programs in those jurisdictions.

The AMA is not aware of any investigation, criminal prosecution, or medical board disciplinary action taken against a physician for the illegal provision of abortion in a state with a strict prohibition. The lack of enforcement action coupled with the data described above from restrictive states suggests that physicians are complying with the laws and have ceased providing prohibited abortion care except when a legally recognized exception applies.

Gender-affirming Care for Minor Patients

As of the writing of this report in March 2024, 23 states have enacted bans on gender-affirming care for minor patients. Twenty-one states (Alabama, Arkansas, Florida, Georgia, Iowa, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Montana, Missouri, North Carolina, North Dakota, Ohio, Oklahoma, South Dakota, Tennessee, Texas, Utah, and West Virginia) broadly prohibit the provision of gender-affirming care to minor patients, including medications to delay puberty, hormonal therapy, and surgeries. Two states (Arizona and Nebraska) prohibit surgical interventions on patients younger than 18 years of age but do not ban non-surgical interventions. Legislative prohibitions on gender-affirming care have been relatively recent developments. The Arkansas legislature enacted the first such law in 2021, followed in 2022 with legislation in Alabama and Arizona and administrative action in Florida and Texas. Twenty-two states then enacted bans in 2023 and 2024.

Among the 23 states that prohibit providing gender-affirming care to minors, some, but not all, impose criminal penalties for violations. In other states, violations are subject to professional discipline, including, in some places, mandatory revocation of the health care professional's license. Several state laws also authorize patients and their families to bring civil suits against health care professionals for decades after the care was provided.

Some laws have been successfully challenged in court. Arkansas's law has been permanently enjoined, and laws in Florida, Idaho, and Montana have been temporarily enjoined in whole or part. Like abortion laws, the status of laws regulating the provision of gender-affirming care is subject to change as legal challenges progress.

At the start of 2023, no law was in effect that broadly prohibited gender-affirming care for minors, though some clinicians and institutions, including in Texas and Tennessee, paused care for minors in response to political pressure.[10] Many laws have since gone into effect, but the full impact is not yet known. It is reasonable to expect that physicians will cease to provide gender-affirming care to their minor patients in compliance with state law. It is also expected that the impact may extend to services provided to transgender adults, as well. For instance, the University of Mississippi Medical Center, which also treated adults, recently closed its gender clinic in response to

legislative activity.[11] Conversely, health care professionals in states that protect gender-affirming care may experience increased demand for services. In contrast to abortion services, however, gender-affirming care generally requires ongoing treatment and monitoring, which could complicate patients' ability to travel to distant locations for care. Additionally, while the impact of state laws on patients and the LGBTQ+ community is immense, those patient outcomes are beyond the scope of this report.

Treatment of Patients with Pain and those with a Substance Use Disorder

The nation's overdose and death epidemic was—and continues to be—driven by a complex set of factors, including the current dominance of illicitly manufactured fentanyl; illicit use of drugs such as heroin, cocaine, and methamphetamine; new toxic adulterants such as xylazine and nitazines; and a lack of access to evidence-based care for pain or a substance use disorder. The history of the epidemic also includes actions of physicians and other health care professionals essentially engaging in drug dealing through what is colloquially termed, "pill mills."[12] As part of its enforcement efforts, several years ago, the U.S. Department of Justice Criminal Division launched a "Prescription Strike Force," which targets "Medicare Part-D fraud and other schemes involving false or fraudulent representations related to prescription medications, in addition to the illegal prescribing, distribution, and diversion of pharmaceutical-grade controlled substances."[13] The U.S. Drug Enforcement Administration (DEA) regularly issues news releases highlighting convictions and other actions against physicians, nurse practitioners and pharmacists for crimes related to "illegally prescribing opioids."[14]

The AMA continues to be concerned about how the actions of the DEA and others in law enforcement have led to what has been referred to as a "chilling effect" in treating patients with pain. In a qualitative review of interviews with 20 West Virginia physicians, the review authors found that physicians' feared discipline even as opioid prescribing was decreasing. Specifically, physicians "felt that taking on patients who legitimately required opioids could jeopardize their career."[15] Stories of patient harm and physician fear are abundant and disturbing to read.[16] But it is important to note that government intrusion into the practice of treating patients with pain or with a substance use disorder has existed for more than 100 years.[17] The Board of Trustees feels strongly that the AMA must continue its decades-long tradition of strongly advocating against third-party intrusion, which includes but is not limited to government intrusion, into the patient-physician relationship.

Notably, ensuring access to evidence-based care for patients with pain or with a substance use disorder remains top priorities for the work of the AMA and the AMA Substance Use and Pain Care Task Force (SUPCTF). AMA advocacy was vital to securing revisions to the 2016 Centers for Disease Control and Prevention (CDC) opioid prescribing guideline. AMA advocacy remains critical in advocating against misapplication of the 2016 CDC opioid prescribing guideline by payers, states, pharmacy chains, pharmacy benefit managers, and others. AMA advocacy also continues to work to remove all barriers to treatment for substance use disorders. This includes helping to lead the national discussion that unequivocally advocates for the understanding that substance use disorders are medical diseases and not moral failings. The Board of Trustees is grateful to the organizations in the SUPCTF for their partnership in furthering these efforts.

Ultimately, it is difficult to specifically quantify the degree to which fear of law enforcement in treating pain or substance use disorders has altered the actual practice of medicine. There is ample anecdotal evidence, but limited research about physician concerns and personal risk assessment. The fear is real, and our colleagues and patients have suffered as a result. In response, AMA will continue to advance its policy opposing third-party/government intrusion into individualized patient care decisions.

DISCUSSION

Opposing third-party intrusion into the practice of medicine (including but not limited to governmental intrusion) has long been a core priority for the AMA. The AMA continues to execute a multifaceted strategy, including engagement with policymakers at the state and federal levels, judicial advocacy, and more, to counter the deleterious impact of legislative efforts to criminalize the practice of medicine. The AMA Advocacy Resource Center continues to work extensively with state medical associations and national medical specialty societies, both publicly and behind-the-scenes, to oppose state laws and regulations targeting the practice of medicine.

Additionally, development of the AMA Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted (Task Force), established by the HOD during the 2022 Annual Meeting, is in progress and the Task Force will update the HOD on its activities, as instructed in Policy D-5.998,

"Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era." The Task Force is well-suited to address the issues raised in this report and will help guide organized medicine's response to the criminalization of medical practice, as well as identify and create implementation-focused practice and advocacy resources on the issues identified in Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," including but not limited to:

1. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;

2. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;

3. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;

4. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;

5. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;

6. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need;

7. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications; and

8. Making recommendations including policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws.

CONCLUSION

The Board of Trustees reiterates its support and gratitude for physicians and all health care professionals who confront the reality of law enforcement or other government intrusion into the practice of medicine. These intrusions have sometimes caused irreparable harms to physicians and patients across the United States. The AMA recognizes that law enforcement plays an important role in our society, but it should not in the exam room, operating suite, or any other patient-physician encounter. Whether it is through the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted to protect access to reproductive rights and gender-affirming care, the Substance Use and Pain Care Task Force to enhance evidence-based care for patients with pain or a substance use disorder; or other areas that must confront the criminalization of health care, the AMA will continue to fight to protect and preserve the sacred nature of the patient-physician relationship.

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21. AMERICAN MEDICAL ASSOCIATION MEETING VENUES AND ACCESSIBILITY

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy G-630.140

At the 2023 Interim Meeting, Board of Trustees Report 12 American Medical Association Meeting Venues and Accessibility responded to Resolution 602-I-22 and proposed amendments to Policy G-630.140 which would have expanded options for meeting venues selection. The Report was referred to the 2024 Annual meeting. Policy G-630.140 (4) states:

> 4. It is the policy of our AMA not to hold meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.

This report responds to referred Board of Trustees Report 12, specifically addressing concerns about assurances and guarantees for personal safety and medical care in an emergency.

DISCUSSION

The Board has heard member concerns and recommends that current policy remain in place and be strictly enforced at all AMA meetings of the AMA. It is at the discretion of the House of Delegates to change current policy.

CONCLUSION

This principled approach reflects the AMA's ongoing commitment to advocating for policies that safeguard reproductive rights and combat discrimination. The organization remains steadfast in promoting an inclusive and supportive environment for all members and attendees.

RECOMMENDATION

The Board therefore recommends Policy G-630.140 be reaffirmed and is strictly enforced as a resolute stance against all forms of discrimination, and support of evidenced-based medicine, underscoring our commitment to fostering an inclusive and safe environment for all attendees. This strategic recommendation places a primary emphasis on prioritizing attendee safety, reflecting the values and principles upheld by the AMA.

Relevant AMA Policy

Policy G-630.140 Lodging, Meeting Venues, and Social Functions
1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.
2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.
3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.
4. It is the policy of our AMA not to hold meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.

5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.
6. All future AMA meetings will be structured to provide accommodations for members and invited attendees who are able to physically attend, but who need assistance in order to meaningfully participate.

22. AMA PUBLIC HEALTH STRATEGY: UPDATE

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: FILED

BACKGROUND

Policy D-440.922, "Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems" adopted by House of Delegates (HOD) at I-21 directed our American Medical Association (AMA) to:

> develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress.

Policy D-145.992, "Further Action to Respond to the Gun Violence Public Health Crisis" has also called for the AMA to report annually to the House of Delegates on our AMA's efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.

This informational report is an effort to provide regular updates on the status of the AMA's mission critical public health work to the HOD. Note that updates on the AMA's work on climate change, firearm violence, and the mental health crisis were provided at I-23.

DISCUSSION

What is Public Health?

Since its founding in 1847, the AMA's mission has been "to promote the art and science of medicine and the betterment of public health." According to the Centers for Disease Control and Prevention (CDC), public health is "the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals."[1] Public health promotes and protects the health of people and the communities where they live, learn, work and play.[2] Public health practice is a different field than clinical medicine with different motivating values, responsibilities, and goals.[3] While a doctor treats people who are sick, those working in public health try to prevent people from getting sick or injured in the first place. A public health professional's duty is to the community rather than an individual patient.

Connection with Health Equity

It is important to acknowledge that health equity is a central concept in public health and is essential to improving the health of populations. The AMA's health equity strategy recognizes that structural and social drivers of health inequities shape a person's and community's capacity to make healthy choices, noting that downstream opportunities provided by the health care system and individual-level factors are estimated to only contribute 20 percent to an individual's overall health and well-being, while upstream opportunities of public health and its structural and social drivers account for 80 percent of impact on health outcomes.[4] The AMA develops an annual report on health equity activities. Progress towards the health equity strategy is reported in the BOT's annual health equity report. (See BOT Report 10, "Center for Health Equity Annual Report.")

AMA PUBLIC HEALTH AND PREVENTION ACTIVITIES

1. Promote evidence-based clinical and community preventive services.

A. Serve as a liaison to the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Community Preventive Services Task Force (CPSTF) and support the dissemination of recommendations to physicians.

In addition to representing the AMA at meetings of these committees and task forces over the last year, the AMA continues to disseminate information on evidence-based preventive services. Examples include:

- The Journal of the American Medical Association (JAMA) publishes the recommendations of the U.S. Preventive Services Task Force. These recommendations are also featured in the AMA Morning Rounds newsletter.
- On March 6, 2024, Michael Barry, MD, Chair of the USPSTF, joined AMA Update to talk about the most impactful final recommendations (new topic to the portfolio, a change in grade, or topics that address the prevention of leading causes of death, and garnered significant attention) and published between January 1, 2023, and December 31, 2023.
- Sandra Fryhofer, MD, the AMA's ACIP Liaison joined the AMA Update podcast throughout the year to provide updates to physicians.
    - On June 27, 2023, she shared what physicians need to know about the new recommendations from CDC's ACIP for RSV vaccines for adults 60 years of age or older.
    - On August 10, 2023, she discussed the details of the new monoclonal antibody immunization recommended to protect babies from RSV. She discussed the details of the immunization including who should get it and what the side effects are.
    - On September 18, 2023, she discussed the ACIP's recommendation that everyone six months and older receive a dose of the new updated COVID vaccine, the XBB.1.5 monovalent version is the 2023-2024 COVID vaccine.
    - On September 28, 2023, she reviewed the ACIP's recommendation on RSV vaccine for pregnant people that would protect infants against the respiratory virus. The vaccine is recommended for use in weeks 32 through 36 of pregnancy, using seasonal administration during September through January.
    - On January 16, 2024, she reviewed the new adult vaccine schedule for 2024.
    - On March 8, 2024, she discussed ACIP's new recommendation in favor of an additional dose of the updated COVID vaccine for all adults 65 and older.
- On November 6, 2023, Jesse Ehrenfeld, MD, MPH participated in a media event with CDC Director, Mandy Cohen, MD, MPH in Chicago to speak with the media about the upcoming respiratory virus season and the immunizations available this year to protect people from COVID, RSV and flu.
- The AMA has also submitted amicus briefs in the case of Braidwood Management v. Becerra, a case that challenges the Affordable Care Act's requirement for private health plans to provide people access to free preventive services. Our AMA advocates for (1) health care reform that includes evidence-based prevention insurance coverage for all; (2) evidence-based prevention in all appropriate venues, such as primary care practices, specialty practices, workplaces, and the community.

B. Help prevent chronic diseases, with a focus on cardiovascular disease, by addressing major risk factors (AMA Strategic Priority led by the Improving Health Outcomes Group)

The AMA is committed to improving the health of the nation and reducing the burden of chronic diseases. Our primary focus is preventing cardiovascular disease (CVD), the leading cause of death in the U.S., accounting for 1 in 4 deaths among adults.[5–7] Two major risk factors for CVD are hypertension and type 2 diabetes. An estimated 122 million adults have hypertension; 98 million have prediabetes and are at increased risk for developing type 2 diabetes.[7,8]

CVD risk factors and associated morbidity and mortality inequitably impact Black, Hispanic/Latinx, Indigenous, Asian/Pacific Islanders, and other people of color. Black adults are more than twice as likely to die of CVD relative to white adults.[9] Black adults have higher prevalence rates for diabetes compared to Hispanic (22 percent compared to 19 percent).[10] While specific causes of the inequities vary by each respective group; structural and societal barriers are attributed as primary reasons.

To prevent CVD and address related health inequities, the AMA is developing and disseminating CVD prevention solutions in collaboration with health care and public health leaders. These solutions educate clinical care teams and patients, guide health care organizations (HCOs) in clinical quality improvement and promote policy changes to remove barriers to care. The AMA disseminates these solutions through strategic alliances with various organizations including the CDC, the American Heart Association (AHA), and West Side United in Chicago.

The AMA MAP ™ Hypertension clinical quality improvement program was designed to improve hypertension management and control. The program has been provided to 46 HCOs across 20 states since 2019. Among those HCOs, 38 percent were in systems that provide free or low-cost care to historically marginalized populations. The AMA MAP ™ set of solutions is expanding to include management for other cardiovascular disease risk factors, including cholesterol, prediabetes, and post-partum hypertension.

Additionally, in response to the high prevalence of uncontrolled blood pressure and to support physicians in managing their patients' high blood pressure, the AMA, in collaboration with AHA, developed Target: BP™, a national initiative offering a series of online resources, using the latest evidence-based information. Target: BP ™ recognizes organizations that have achieved milestones in their commitments to improving blood pressure control. In 2023, Target: BP ™ 1,709 HCOs participated in the Target: BP™ Achievement Awards including 868 HCOs that reported control rates greater than or equal to 70 percent and/or 1,493 HCOs that attested to evidence-based blood pressure measurement practices, like using the US Validated Blood Pressure Device Listing (VDL™). Participants came from 47 states or U.S. territories and served about 33 million patients, including 8.6 million people with hypertension.

AMA Prevent Diabetes houses a suite of tools and resources designed to help organizations build and integrate diabetes prevention strategies into their organizations. AMA has worked with more than 80 health care organizations across the country to increase identification and management of patients with prediabetes. This suite of tools and resources and AMA's related expertise served as the basis for the Bright Spot Model, which provided structure for local initiatives in Philadelphia and North Carolina to advance diabetes prevention. AMA has since transitioned the Bright Spot model to the CDC who is now expanding the reach of the model by funding four organizations with $10 million for implementation. As part of this implementation, CDC is requiring funded organizations to work with HCOs to implement the AMA Prediabetes Quality Measures. AMA will continue to make our suite of tools and resources available to support this effort.

In 2023, the AMA in its partnership with the AHA, closed Medicaid coverage gaps to ensure that beneficiaries could receive home blood pressure devices and have their condition monitored by physician-led care teams. The AMA was also successful in closing a Medicare coverage gap; hemoglobin A1c lab tests are now a covered screening test which could result in more high-risk individuals getting screened, diagnosed, and referred to a preventive intervention.

Another CVD risk is obesity which is associated with cardiovascular disease mortality independent of other cardiovascular risk factors.[11] The AMA is working with Federation members including the American College of Physicians and Obesity Medicine Association to identify opportunities to improve access to evidence-based obesity treatments.

C. Collaborate with CDC to improve the implementation of routine screening for HIV, STI, Viral Hepatitis and latent tuberculosis (LTBI).

Through funding from the CDC, the AMA has been engaged in a project entitled, "Promoting HIV, Viral Hepatitis, STDs and LTBI Screening in Hospitals, Health Systems and Other Healthcare Settings." The scope of this project includes developing, piloting and launching a toolkit that outlines ways to increase routine screening for HIV, STIs, viral hepatitis and LTBI. The toolkit consists of a series of webpages on the AMA's website. Information and strategies are organized along the screening and testing continuum and offer helpful resources and best practices from the AMA, CDC and other organizations. The toolkit contains two different sets of strategies – one targeted to community health centers and a second to emergency departments.

On October 1, 2023, the AMA launched a pilot with four emergency departments, after completing a community health center pilot earlier in the year. The emergency department pilot cohort includes: Harris Health Ben Taub Hospital (staffed by Baylor College of Medicine physicians and residents), Mayo Clinic, University of Colorado and

Valleywise Health. Each pilot site selected 2-3 quality improvement strategies outlined in the routine screening toolkit to implement in their emergency department. Sites also provided tangible feedback to the AMA on the effectiveness of these strategies and ease of implementation in addition to providing input on the overall toolkit itself. The AMA held a series of telementoring sessions for the pilot sites, which were moderated by Megan Srinivas, MD, MPH and Marc Mendelsohn, MD. The pilot sites will conclude their implementation work and post-pilot assessment activities by the end of April 2024.

Upon addressing critical feedback we received on the toolkit during a mid-point usability study with the emergency department pilot sites, we launched the toolkit to the public with a press release on March 6, 2024.[12] In conjunction with the launch of the toolkit, we are hosting a three-part webinar series that highlights key strategies to improve routine screening. The series will be hosted by AMA President Jesse Ehrenfeld, MD, MPH. The first episode in the series will feature Jonathon Mermin, MD, MPH, director, National Center for HIV, STIs, Viral Hepatitis and LTBI at the CDC.[13]

D. Promote evidence-based preventive services to the public in collaboration with the Ad Council and other health partners.

While the AMA's primary audience is physicians, there are limited instances where the AMA has partnered on public information campaigns on select priority issues. This work has been made possible through partnerships with other health-related organizations and the Ad Council. The AMA will explore opportunities for future campaigns on an ongoing basis, with recognition that we must prioritize our efforts and engaging in these campaigns alone is not feasible due to cost.

Get My Flu Shot. The Ad Council, AMA, CDC and the CDC Foundation have partnered since the 2020-2021 flu season through an annual campaign to motivate more people to get vaccinated against seasonal influenza (flu) to protect themselves and their loved ones. During a severe season, flu has resulted in as many as 41 million illnesses and 710,000 hospitalizations among the U.S. population. The Get My Flu Shot campaign PSAs are launched nationwide to reach people with the message that a flu shot can help you stay healthy, reduce risk of severe outcomes, such as hospitalization and death, and avoid missing work, school, or special moments with family and friends. PSAs are available to run in English and Spanish across all platforms, in donated time and space throughout flu season. The campaign ads direct audiences to GetMyFluShot.org for more information, including where to get a flu vaccine in their area. Some highlights from the 2023-24 flu campaign are as follows:

- The donated media value for the current Flu season reached nearly $8.8M. The most support has come from out of home (OOH - $4,500,471), closely followed by TV support ($3,794,079).
- A media tour was held on September 19, 2023, in English and Spanish, featuring spokespeople from the AMA, including Willie Underwood, MD, MSc, MPH and Madelyn Butler, MD, and representatives from the CDC. Nearly 300 placements were secured across TV, radio, and digital, with a reach of 2 million viewers (18 years of age or older), 53.8 million digital impressions, and 2.3 million broadcast impressions.
- A second media tour was held on December 12, 2023, in English and Spanish, with spokespeople from the AMA, including Willie Underwood, MD, MSc, MPH and the CDC. Nearly 100 placements across TV, radio, and digital were secured with a reach of 3.2 million viewers (18 years of age or older), 191.1 million digital impressions, and 3.5 million broadcast impressions.
- We partnered with Influential and Black Girl Digital for our trusted messenger activation on social media. There was a total of 11M impressions, an estimated reach of 2.5M, 65k engagements, and 9k link clicks. There was an overall positive sentiment (81 percent) towards the posts.
- PSA awareness is now 56 percent in Black and Hispanic respondents based off our most recent December 2023 tracking study.

2. Responding to public health crises impacting physicians, patients, and the public.

The AMA's public health work has also been focused around responding to public health crises. These crises are often associated with significant health risk for patients, raising concerns among physicians. However, these crises are unlikely to be solved in a clinical setting alone. The AMA's response to public health crises are typically focused on (1) ensuring physicians and trainees have the data and resources needed; (2) identifying evidence-based policies and interventions; (3) elevating the voices of physician leaders through AMA channels and platforms; and (4) convening and collaborating with stakeholders to advance priority policies and interventions.

A. Address the public health crisis of climate change.

At the 2022 Annual Meeting of the House of Delegates, policy was adopted declaring "climate change a public health crisis that threatens the health and well-being of all individuals." Since the A-23 meeting, AMA has accomplished the following activities and is developing a formal strategy to address climate change and health (anticipated release is the AMA I-24 meeting):

- The AMA has made climate change education available via the Ed Hub™ from a variety of sources including the AMA Journal of Ethics (JOE), the Journal of the American Medical Association (JAMA), and the American Public Health Association (APHA).
- AMA's Chief Health & Science Officer, Frederick Chen, MD, MPH, joined the August 24, 2023, PermanenteDocs Chat podcast on heat waves and health, with a focus on how physicians can adjust to prepare to care for heat-related conditions brought on by climate change.
- JAMA announced the introduction of its new climate change and health series.[14] The new series is intended to inform readers about the associations between climate change and health and "to stimulate improved knowledge and understanding of the health effects of climate change to help foster commitment to timely action to prevent adverse health events from climate change."
- The AMA is in the process of developing a new CME module for physicians and trainees on climate change and health which is anticipated to be available in summer 2024. The focus of the module is to bring awareness to physicians about the impact of climate change on the nation's health and to empower physicians to begin conversations with their patients about how climate change is affecting their health and what they can do about it.
- The AMA created a new webpage on AMA's website, *Advocacy in action: Combating health effects of climate change*, to highlight AMA's position on this issue, how it is engaged, and resources for physicians.[15]
- On November 2, 2023, AMA Update featured Victor Dzau, MD, President of the National Academy of Medicine (NAM), to discuss how their Action Collaborative on Decarbonizing the U.S. Health Sector is bringing together organizations across health care to take action on climate change.[16]
- At the Interim 2023 meeting, the Health, Science, and Ethics business unit, in collaboration with NAM, hosted an educational session entitled T*he Climate Crisis: Pathways to Decarbonizing the U.S. Health Sector*. The session featured four speakers who spoke to ways that health care professionals can lead meaningful and measurable changes in combating climate change, identified common barriers to decarbonization, and provided available resources to support action towards decarbonization. Although overall attendance was not counted, 48 individuals claimed CME credit for attending the event and the average quality rating was 4.8/5.0.
- In early spring 2024, the AMA STEPS Forward® Podcast featured Jerry Abraham, MD, MPH, who discussed the intersections between the social determinants of health and climate change impacts.
- The AMA submitted an abstract to the American Public Health Association (APHA) annual conference to be held in October 2024 to present on the findings from the listening sessions held with physicians in May 2023 on climate change and health.
- The AMA continues to engage in the Medical Society Consortium on Climate and Health (Consortium), which brings together associations representing over 600,000 clinical practitioners.[17] The AMA sits on the executive committee of this group, represented by Ilse Levin, DO, MPH & TM. Additionally, the AMA was a sponsor of the MSCCH Annual Meeting held in February 2024 in Washington, DC. Dr. Levin and AMA staff attended the meeting.
- The AMA is also a member of the NAM Action Collaborative on Decarbonizing the Health Sector as a member of the Steering Committee and co-lead of the Health Care Delivery Workgroup.
    - The first phase (2021-2023) of the Action Collaborative's work has been focused on identifying key opportunities and challenges to climate action, decarbonization, and building resiliency across the health sector and developing resources and tools to meet those needs. The collaborative, through the work of the members have completed over thirty resources to accelerate climate action across the health sector.
    - The second phase (2024-2025) will consist of accelerating a national climate and health movement, as well as advancing the successes of the existing working groups and launching an accelerator pilot program.
- The AMA is represented on the APHA Center for Climate, Health, and Equity Advisory Board. In February 2024, the Advisory Board organized a roundtable of public health experts to discuss the health, climate and equity priorities for consideration of the reauthorization of the federal transportation bill, which is scheduled to be renewed in 2025.

- The AMA was also represented at APHA's first Climate, Health and Equity Summit in late February 2024, which brought together professionals from across multiple disciplines to explore the intersectionality of climate, health and equity and strategize how professionals can advance public health and climate justice.

In terms of advocacy, the AMA participates in the American Lung Association's Healthy Air Partners campaign, which is a coalition of 40 national public health, medical, nursing and health care organizations engaged in healthy air advocacy efforts.[18] The Coalition is united in its calling for strong federal laws and policies to slash air pollution and address climate change, recognizing climate change can affect air quality, and certain air pollutants can affect climate change. Since June 2023, the AMA has joined partners on the following letters:

- A letter to Environmental Protection Agency (EPA) on their proposed ruling regarding Pollutant Emissions Standards for Model Years 2027 and Later Light- Duty and Medium-Duty Vehicles, urging them to pass the most stringent emission standards possible with existing technologies.
- A letter to EPA on their proposed ruling regarding National Emission Standards for Hazardous Air Pollutants: Coal- and Oil-Fired Electric Utility Steam Generating Units Review of the Residual Risk and Technology Review.
- A letter to EPA on their proposed ruling in the Reconsideration of the National Ambient Air Quality Standards for Particulate Matter, calling for the most protective standards to protect the health of the most vulnerable populations. To note, EPA finalized their particulate matter rule on February 7, 2024.[19] While the new rule did not set particulate matter at the more protective standard as advocated for by the Healthy Air Partners group, the revised rule did address several of our comments and the new standards will result in significantly reduced particular matter pollution in the future.
- A letter to EPA on their draft Revised Technical Guidance for Assessing Environmental Justice in Regulatory Analysis, which included the addition of climate change as a factor of vulnerability when conducting environmental justice analysis.

B. Prevent firearm injuries and deaths.

In the 1980's the AMA recognized firearms as a serious threat to the public's health as weapons are one of the main causes of intentional and unintentional injuries and deaths. At the 2016 Annual Meeting, following the Pulse nightclub shooting, policy was adopted declaring that "gun violence represents a public health crisis which requires a comprehensive public health response and solution." Since that time firearm injuries and deaths have increased and disparities have widened.[20]

- The AMA is participating in the Health Professional Education and Advocacy/Policy committees of the Healthcare Coalition for Firearm Injury Prevention, which is being led by American Academy of Pediatrics (AAP), American College of Emegency Physicians (ACEP), American College of Physicians (ACP), American College of Surgeons (ACS), and the Council of Medical Specialty Societies (CMSS).[21]
- On October 25–26, 2023, Alexander Ding, MD, MS, MBA, represented the AMA at the Milken Institute's Innovation Forum on Preventing Gun Violence in San Francisco. This first-of-its-kind convening explored how technologies, expanded community collaboration, and innovative models could unlock real progress to prevent gun violence and address its societal repercussions.
- On December 14, 2023, the AMA convened the Firearm Injury Prevention task force for an in-person meeting held at AMA Headquarters in Chicago. Willie Underwood, MD, MSc, MPH, Chair of the AMA Board of Trustees and the task force led the meeting along with task force Co-Vice Chairs Toluwalasé (Lasé) Ajayi, MD, and Alexandar Ding, MD, MS, MBA. Representatives to the task force discussed their organization priorities on firearm injury prevention, examined the possibility of creating a resource center on firearm injury prevention for physicians that would include information for patients and resources on evidence-based interventions, and discussed the development of a toolkit for physicians on extreme risk protection orders.
- On February 7, 2024, the AMA was represented by Willie Underwood, MD, MSc, MPH, at the Northwell Health's Gun Violence Prevention Forum in New York City.
- On March 4, 2024, the AMA convened a virtual meeting of the Firearm Injury Prevention task force, where the members had the opportunity to hear from the Ad Council both about their ongoing gun violence work as well as their new campaign, funded by members of the National Health Care CEO Council on Gun Violence Prevention and Safety. The new campaign seeks to elevate the issue of gun violence in America and its impact on youth, shifting away from divisive, politically charged conversations to those focused on public health approaches that have proven effective in combating this epidemic.

In terms of advocacy, the AMA has advocated for Congress to appropriate increased funding for research to prevent firearm violence. The AMA is working with medical specialties, including the AAP, to support funding for the CDC and the National Institutes of Health (NIH), and the National Institute of Justice (NIJ) to conduct public health research on firearm morbidity and mortality prevention.

- On April 19, 2023, the AMA joined more than 400 national, state, and local medical, public health, and research organizations in a letter to the leadership of the House and Senate Committees on Appropriations asking that for Fiscal Year (FY) 2024 they appropriate $35 million for the CDC, $25 million for the NIH, and $1 million for the NIJ to conduct public health research into firearm morbidity and mortality prevention.

On the state level, the AMA wrote a letter to the leadership of the Maine Health and Human Services and Judiciary Committees on March 4, 2024, expressing our support for legislation that will address the epidemic of firearm violence in Maine and across the country, this includes:

- Legislative Document (LD) 2237 - An Act to Strengthen Public Safety, Health and Well-being by Expanding Services and Coordinating Violence Prevention Resources. AMA policy supports many of the initiatives in this comprehensive legislation, and applauds the investment in violence prevention strategies, access to behavior health services, suicide prevention, and crisis intervention programs. (Policies H-145.975, D-345.972, H-345.972, and H-60.937)
- LD 2086 - An Act to Amend the Law Governing the Disposition of Forfeited Firearms. The AMA supports removal of firearms from prohibited persons. (Policy H-145.972)
- LD 2224 - An Act to Strengthen Public Safety by Improving Maine's Firearm Laws and Mental Health System. AMA Policy advocates for a waiting period and background check for all firearm purchasers and policies that prevent transfer of firearms without adhering to background checks. The AMA also applauds efforts to expand access to mental health and substance use disorder treatment. (Policies H-145.996 and H-145.975)
- LD 2238 - An Act to Address Gun Violence in Maine by Requiring a Waiting Period for Certain Firearm Purchase. AMA Policy supports legislation that enforces a waiting period and background check for all firearm purchasers. (Policy H-145.996)

Through the AMA's litigation center, we work to represent the interests of the medical profession on this issue in the courts by providing support or becoming actively involved in litigation of importance to physicians.

- On August 21, 2023, the AMA was joined by the AAP, the ACS, the AP HA and the Texas Medical Association in submitting an amicus brief in the case of *U.S. vs. Rahimi*, which was argued on November 7, 2023, before the U.S. Supreme Court. The case challenges a 1994 law adopted by Congress to keep firearms out of the hands of people who are the subject of a domestic violence restraining order (DVRO). The brief shares firsthand accounts from 17 physicians who have witnessed the devastating injuries and deaths caused by domestic abusers with firearms, as well as the often-lifelong psychological terror inflicted upon victims, their children, and others.
- On December 26, 2023, the AMA was joined by the AAP, ACP, and ACS in submitting an amicus brief in the case of *Garland v. Cargill*. The case involves firearms, namely whether a bump stock device is a machinegun under federal law, as it allows users to convert a semiautomatic firearm into a weapon that fires continuously with a single trigger pull. The brief presents the firsthand experiences of physicians who treat victims of firearm violence and explains why semi-automatic weapons with bump stocks are a critical public health hazard, and prohibiting bump stocks saves lives.

The AMA has created a website broadly outlining the organization's advocacy efforts on gun violence prevention.[22]

C. Respond to emerging and remerging infectious disease threats and prepare for future pandemics.

Infectious diseases continue to evolve and advance throughout the U.S. Pathogens that were once geographically limited are now advancing beyond those traditional borders. Blastomycosis, Histoplasmosis and Coccidioidomycosis are all fungal infections that have pushed past expected boundaries. In addition to organisms known to be found in the U.S., tropical diseases like malaria, dengue and Leishmaniasis have all been found in the U.S. in nontravelers. Re-emerging pathogens like measles continue to find footholds across the country. While it's unclear what the next infectious diseases outbreak will bring, the U.S. health system must be ready. Because the AMA is relied upon as a source of information by physicians and patients, the AMA must maintain the ability to respond and share information and advocate for physicians, patients, and the public in line with AMA policies.

The AMA is a collaborator in Project Firstline, the CDC's National Training Collaborative for Healthcare Infection Control. Project Firstline offers educational resources in a variety of formats to meet the diverse learning needs and preferences of the health care workforce.[23]

- Over the last year, AMA has developed 10 *Stories of Care* podcast episodes exploring inequalities in infection prevention and control (IPC). The podcast series is hosted by Megan Srinivas, MD, MPH, and has featured episodes on IPC Challenges in Rural Health Care; Race, Research, and Health Care Associated Infections; TB or Not TB: Caring for a Special Population; Fighting Ableism: What Do You Need?; The Hidden Inequities of Dialysis-Related Infections; and Partners in Care: Environmental Services on the Front Line.
- The AMA provided funding to 7 state and specialty medical societies to develop training and IPC content for the membership and disseminate Project Firstline content.
- The AMA has partnered with the CDC on webinars addressing re-emerging pathogens and the end of the COVID-19 public health emergency.
- On December 12, 2023, Sandra Fryhofer, MD, hosted a fireside chat to discuss vaccinations and other tools that can keep everyone safer against influenza, COVID-19, and respiratory syncytial virus (RSV) this respiratory virus season. Participants included CDC Director Mandy Cohen, MD, MPH and Demetre Daskalakis, MD, MPH.
- The AMA hosted a five-part webinar series with the CDC on its Hospital Sepsis Program Core Elements, which offer guidance to help clinicians, hospitals and health systems implement, monitor and optimize their sepsis programs and outcomes. The series included real-life examples, strategies and best practices and offers continuing education credit.
- A tele-mentoring series will kick off in April of 2024 that will explore the nuances of infection prevention in facility types outside of the acute care hospital. Settings will include acute rehabilitation hospitals, ambulatory surgery centers, behavioral health units, post-acute long-term care facilities, dialysis facilities, and pediatric units.
- A CME module is under development that will present patient cases outlining transmission-based precautions so that physicians and other health care professionals can recognize how to protect themselves in any situation.

D. End the nation's drug overdose epidemic.

Ending the nation's drug overdose epidemic will require increased physician leadership, a greater emphasis on overdose prevention and treatment, and better coordination and amplification of the efforts and best practices already occurring across the country.

The AMA makes education available to physicians on this topic via the AMA Ed Hub™ to help physicians gain critical knowledge around acute and chronic pain management, substance use treatment, overdose prevention, and pain treatment to meet the regulatory requirements. Courses are developed by AMA as well as by other partners. The AMA is also a member of the Providers Clinical Support System (PCSS), which is made up of a coalition of major health care organizations all dedicated to addressing this health care crisis and is led by the American Academy of Addiction Psychiatry. PCSS provides evidence-based training and resources to give health care providers the skills and knowledge they need to treat patients with opioid use disorders and chronic pain.[24]

- In 2023 the AMA worked to update content and resources for the physician education series of module *Practical Guidance or Pain Management*. This content was made available to help physicians meet the DEA's MATE Act requirements.
- The AMA continues to convene the Substance Use and Pain Care Task Force, which supports and guides the development of the annual Overdose Epidemic Report on the overdose epidemic outlining current data, policy, updates, clinical accomplishments and what still needs to be done.[25]
- In 2023, the AMA developed physician education podcast series on *The Opioid Overdose Epidemic*. Hosted by Bobby Mukkamala, MD, Chair of the Substance Use and Pain Care Task Force, episodes feature experts who shared relevant research, insights, and experience to help physicians of all specialties in addressing the opioid overdose epidemic. As of November 2023, the podcast episode course completions have shown a high interest in the topics, which include: *Opioid Prescribing and Appropriate Pain Management, Opioid Overdose Prevention, and Opioid Use Disorder Treatment.*
- The AMA is planning additional episodes as a part of this series for 2024, which will consist of four episodes including: *Opioid Use Disorder and Pregnancy, Opioid Utilization in Hospice and Palliative Care, Disparities in Access to Medication for Opioid Use Disorder, and Opioid Use a Prevention Approach*.

- The AMA continues to participate as a member of the NAM Action Collaborative on Countering the U.S. Opioid Epidemic. The Action Collaborative uses a systems approach to convene and catalyze public, private, and non-profit stakeholders to develop, curate, and disseminate multi-sector solutions designed to reduce opioid misuse, and improve outcomes for individuals, families, and communities affected by the opioid crisis.

3. Strengthen the health system through improved collaboration between medicine and public health.

The AMA is collaborating with leading health care organizations to strengthen the interface between public health and health care.

- In November 2023, AMA and health care partners announced the Common Health Coalition: Together for Public Health, a partnership between AMA and four other leading healthcare organizations, including: AHIP (formerly America's Health Insurance Plans), Alliance of Community Health Plans (ACHP), American Hospital Association (AHA), and Kaiser Permanente (KP).[26] The Common Health Coalition is focused on translating the hard-won lessons and successes of the COVID-19 pandemic response into actionable strategies that will strengthen the partnership between our health care and public health systems.
- On March 13, 2023, the Common Health Coalition announced a set of commitments that will better equip U.S. health care organizations to collaborate with public health systems in preparing for the next public health emergency. Dave Chokshi, MD, MPH, Chair of the Coalition announced the commitments at the Politico Health Summit. The Coalition's founding members, including the AMA, committed to action in four priority areas:
    - **C**oordination between health care and public health
    - **A**lways-on emergency preparedness
    - **R**eal-time disease detection
    - **E**xchange of actionable data, particularly to advance equity
- The Coalition's founding members have called on health care and public health organizations across the country to consider joining this effort. Interested organizations can learn more, connect with us, and take steps to join us by going to our website, https://commonhealthcoalition.org/.
- On April 11, 2024, the AMA was represented on a panel at the KP Health Summit in Washington, D.C., focused on *Building a Strong Public Health Ecosystem.* This session explained the commitments the Coalition has made and actions each organization will take to create a strong public health system and healthier future for all.

4. Combat the spread of misinformation and disinformation.

The AMA remains engaged in external collaborations to address mis- and disinformation, such as the Coalition for Trust in Health & Science and the recently rebranded physician-focused coalition, Mitigating Medical Misinformation Workgroup.

- The Coalition for Trust in Health & Science's vision is for all people to have equitable access to accurate, understandable, and relevant information to make personally appropriate health choices and decisions. The AMA is an active member, engaging with leadership and participating in programming.
- The AMA is also an active participant in the Mitigating Medical Misinformation Workgroup and supported its recent research that found primary care physicians were viewed as the most trusted source for medical information. The AMA will work with this group to disseminate these findings to a broader audience in 2024 and will continue to coordinate efforts internally to ensure alignment.
- The AMA filed an amicus brief with the U.S. Supreme Court in the case of *Murthy v. Missouri.* The brief focuses on how disinformation diminished uptake of COVID-19 vaccines, which then limited the vaccines' ability to save lives by controlling the spread of disease—thereby creating a compelling interest for the government to act. The high court will hear oral arguments in the case on March 18, 2024.

CONCLUSION

The AMA continues to advance its mission, to promote the art and science of medicine and the betterment of public health. The highlighted accomplishments in this report capture a fraction of the work accomplished from March of 2023 – March of 2024 related to the AMA's public health strategy.

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23. UNITED STATES PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH OBSERVER STATUS IN THE HOUSE OF DELEGATES

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy G-600.025

The Board of Trustees has received a request from the United States Professional Association for Transgender Health (USPATH) to be considered for Official Observer status in the House of Delegates (HOD). The USPATH's request has been thoroughly considered using the criteria below (Policy G-600.025, "Official Observers in Our AMA House"):

1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both;
2. The organization should be national in scope and have similar goals and concerns about health care issues;
3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD; and
4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

The Board has discussed the USPATH's request and presents the following report.

DISCUSSION

As part of its request, USPATH submitted information on how it has met the criteria for Official Observer status, which is summarized below.

Criterion 1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both.

USPATH has established informal relationships with the AMA through member and board member involvement in the AMA Advisory Committee on LGBTQ Issues as well as the business of the AMA HOD. Given their national scope, USPATH shares similar goals and concerns as the AMA in ensuring appropriate access to and practice of evidence-based medicine and the elimination of barriers to care placed between physicians and their patients.

Criterion 2. The organization should be national in scope and have similar goals and concerns about health care issues.

USPATH is regional affiliate organization of the World Professional Association for Transgender Health (WPATH), which is an interdisciplinary professional and educational organization devoted to transgender health. USPATH professional, supporting, and student members engage in clinical and academic research to develop evidence-based medicine and strive to promote a high quality of care for transgender and gender-nonconforming individuals within the US.

As a national interdisciplinary, professional organization, USPATH works to further the understanding and treatment of gender dysphoria by professionals in medicine, psychology, law, social work, counseling, psychotherapy, family studies, sociology, anthropology, sexology, speech and voice therapy, and additional related

fields. USPATH provides opportunities for professionals from various sub-specialties to communicate with each other in the context of research and treatment of gender dysphoria including sponsoring biennial scientific symposia. USPATH is a regional affiliate of WPATH, which publishes the Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, which articulate a professional consensus about the psychiatric, psychological, medical, and surgical management of gender dysphoria and help professionals understand the parameters within which they may aid those with these conditions. The Standards of Care are frequently cited to support current AMA policy regarding gender-affirming care.

Criterion 3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD.

Given their multi-disciplinary membership and focus on a particular area of health care, USPATH will add a unique perspective and bring expertise to the deliberations of the AMA HOD.

Criterion 4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

The USPATH does not represent narrow religious, social, cultural, economic, or regional interests and has already been welcomed to participate in previous AMA activities.

The Board of Trustees appreciates the previous involvement of USPATH with the AMA Advisory Committee on LGBTQ Issues and believes that the USPATH should be recognized as an Official Observer and welcomed to the House in that capacity.

RECOMMENDATION

The Board of Trustees recommends that the United States Professional Association for Transgender Health be admitted as an Official Observer in the House of Delegates, and that the remainder of this report be filed.

Appendix - Official Observers to the House of Delegates

Organization	Year Admitted
Accreditation Association for Ambulatory Health Care	1993
Alliance for Continuing Medical Education	1999
Alliance for Regenerative Medicine	2014
Ambulatory Surgery Center Association	2005
American Academy of Physician Assistants	1994
American Association of Medical Assistants	1994
American Board of Medical Specialties	2014
American Dental Association	1982
American Health Quality Association	1987
American Hospital Association	1992
American Nurses Association	1998
American Public Health Association	1990
American Podiatric Medical Association	2019
Association of periOperative Registered Nurses	2000
Association of State and Territorial Health Officials	1990
Commission on Graduates of Foreign Nursing Schools	1999
Council of Medical Specialty Societies	2008
Educational Commission for Foreign Medical Graduates	2011
Federation of State Medical Boards	2000
Federation of State Physician Health Programs	2006
Medical Group Management Association	1988
National Association of County and City Health Officials	1990
National Commission on Correctional Health Care	2000
National Council of State Boards of Nursing	2000
National Indian Health Board	2013

PIAA	2013
Society for Academic Continuing Medical Education	2003
US Pharmacopeia	1998

24. REPORT ON THE PRESERVATION OF INDEPENDENT MEDICAL PRACTICE

Informational report; no reference committee hearing.

HOD ACTION: FILED

BACKGROUND

At its 2022 Annual Meeting, the House of Delegates (HOD) adopted Resolution 602, "Report on the Preservation of Independent Medical Practice," which directed the American Medical Association (AMA) to issue a report every two years communicating AMA efforts to support independent medical practices.

Resolution 602 appended AMA policy D-405.988, The Preservation of the Private Practice of Medicine, which among other things affirmed the Association's support for the preservation of private practice and the acknowledgement of its value to the practice of medicine and its benefit to patients.

This report serves as the first instance of a biennial accounting of the activities the AMA has engaged in since 2022 to support independent practices.
DISCUSSION

The AMA's efforts to promote and advocate for independent practice physicians can be summarized in three key strategic efforts:

- providing a voice for independent physicians in the AMA House of Delegates and beyond,
- conducing outreach to current and future independent physicians, and
- promoting resources for the advancement of independent practices

Providing a Voice for Independent Physicians in the HOD and Beyond

The AMA's newest section, the Private Practice Physicians Section (PPPS), was officially established at the November 2020 Special Meeting of the HOD and held its first meeting in conjunction with the June 2021 Special Meeting of the HOD. Though certainly not the only unit within the Association working on behalf of independent practices, the PPPS is the primary vehicle for addressing the concerns of private practice physicians within the HOD, thus helping to ensure that independent practice concerns are considered when determining policy.

The PPPS maintains a roster of 367 certified members. Membership is open to any AMA member who is in a practice consisting of 50 or fewer physicians and in which the physicians maintain a controlling interest in the practice. Physicians must independently elect to join the section; they are not at this time proactively asked if they want to join, though they are made aware of the Section's existence. Membership in the PPPS has grown significantly since 2022, with the Section adding 53 new members in 2022 (+20%), and 44 new members in 2023 (+14%).

The Section has held formal Business Meetings at all AMA Annual and Interim meetings since June of 2021. Attendance has been strong, fluctuating between approximately 40 and 60 members attending each meeting. The PPPS has advanced 18 resolutions to the House of Delegates since the 2022 Annual Meeting on topics such as reexamining laws around physician self-referrals, limiting corporate ownership of private practices, improving Medicare reimbursement, and developing guidelines for the use of virtual and overseas administrative assistants, among many others.

The AMA has championed issues important to private practice in its advocacy efforts, particularly at the federal level. Key among these issues is reforming Medicare payment rates to ensure practices can continue to thrive. The AMA believes the need to stop the annual cycle of pay cuts and patches and enact permanent Medicare payment reforms could not be clearer. The AMA was successful in getting Congress to introduce H.R. 2474, the

Strengthening Medicare for Patients and Provider Act, which would provide automatic, annual payment updates to account for inflation as reflected in the Medicare Economic Index (MEI). The AMA and our Physician Grassroots Network and Patient Advocacy Network consider the passage of H.R. 2474 to be among its highest priorities.

The AMA is also engaging directly with federal decision-makers on fixing prior authorization, limiting scope creep, supporting telehealth, surprise billing, and protecting against government intrusion in areas such as abortion care and gender-affirming care. The AMA has submitted comments on the Federal Trade Commission's proposed rule on noncompete agreements and Department of Justice antitrust merger guidelines. The AMA also advocates before Congress and the Centers for Medicare and Medicaid Services that the Stark exemption for physician-owned hospitals needs to be restored.

The cyber security attack on Change Healthcare in March 2024 has left many independent physician practices struggling to stay on top of their operations. The AMA is working closely with members who have experienced disruptions to share instructions for getting federal emergency funds, guides for managing impact, and connecting physicians' experiences directly to the United States Department of Justice.

Outreach to Independent Physicians

For the past three years, the PPPS has hosted a virtual Private Practice Townhall each March or April, serving as an open forum for independent physician members to raise issues they may be experiencing in their practices and share ideas for addressing them. The Townhall not only provides valuable real-world intelligence about the issues private practices are experiencing to the leadership of the PPPS, but it also affords an opportunity for physicians to connect as peers to share tips and best practices. Additionally, the Townhall typically inspires ideas for education sessions at PPPS Business Meetings as well as generates new policy proposals.

The PPPS has also collaborated with the AMA's Professional Satisfaction and Practice Sustainability (PS2) team. The two are currently planning a private practice "bootcamp" to be held in advance of the 2024 Annual Meeting. The "bootcamp" will be a multi-hour training session on the business of private practice, giving attendees opportunities to better understand how to effectively manage their business while continuing to provide care to patients. The program stems from ideas raised in previous PPPS Townhalls as well as open discussions at PPPS Business Meetings and other AMA events.

Promoting Resources for the Advancement of Independent Practices

The AMA's STEPS Forward® initiative, part of its Innovation Academy, has made a suite of interactive open-access resources tailored for independent practices available through the AMA EdHub™, many of which are available for continuing medical education credit. These include podcasts, toolkits, and webinars available online to members and non-members.

Specifically, STEPS Forward® has crafted a series of tools and materials designed to help physicians who are either new to private practice or who simply seek to better operationalize their practice. Key examples include:

- 7 STEPS to Starting a Private Practice visual guide
- Private Practice Playbook – a repository of sample forms including a model new patient packet, routine patient documents such as medical release and patient payment plans, administrative documents such as refund requests and medication logs, employee documents for job descriptions and expense reimbursement, and new hire documents such as model confidentiality agreements and drug screen consent forms.

Independent physicians who are AMA members also have access to a range of experiential sessions in the form of webinars to help physicians better capitalize on their practices' regular financial and operational tasks. This programming is offered through the AMA's Private Practice Simple Solutions sessions, of which 17 programs have been offered since 2022. Key examples of programming for independent practices include sessions on practice marketing, conducting market research to better understand the needs of the community, public relations and establishing community trust, and maximizing referral strategies. These programs are operated and promoted by the AMA's PS2 team.

The PPPS has offered additional educational programming at its Annual and Interim meetings. Designed and curated to address issues that PPPS members most frequently raise as key issues for their practice, the Section routinely works with internal and external subject matter experts to share strategies and information to attendees. Recent examples of educational sessions offered at PPPS meetings include a legal analysis of employment contracting from the perspective of both the employer and employee, an unpacking of innovative business model strategies from three different independent physician practices, a strategic assessment of methods for transitioning a practice, and a breakdown of best practices for branding and marketing.

CONCLUSION

The AMA continues to be mindful of the rate of change in the physician practice setting with greater numbers of physicians opting to leave private practice each year. The strategies and initiatives outlined here represent the foundations the AMA will build upon to continue to ensure that independent physician practices have the support they need to thrive. The AMA will continue to promote the resources it has while expanding its menu of services and tools geared toward physicians in private practice.

25. ENVIRONMENTAL SUSTAINABILITY OF AMA NATIONAL MEETINGS

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 603-A-23 AND 608-A-23
TITLE CHANGED
REMAINDER OF REPORT FILED
See Policy G-600.004

At the 2023 Annual Meeting, Resolutions 603- Environmental Sustainability of AMA National Meetings and 608 - Supporting Carbon Offset Programs for travel for AMA Conferences were introduced. Both resolutions received testimony in favor of referral. Testimony also suggested that our American Medical Association (AMA) lead the health care profession by example and that a strategic plan to address environmental sustainability be developed with attention to fiscal impact. This report is in direct response to the two referred resolutions addressing AMA's commitment to sustainability of AMA National Meetings and exploring supporting carbon offset programs for travel for AMA Conferences

DISCUSSION

The AMA recognizes the imperative to lead by example and play a proactive role in promoting environmental stewardship within the health care community. Resolutions 603 and 608 calls for the AMA to commit to reducing carbon emissions and fostering a more sustainable future. Resolution 603 calls for the AMA to commit to reaching net-zero emissions for its business operations by 2030, and advocates for the reduction of emissions within the broader health care system.

Resolution 608 focuses on the importance of mitigating carbon emissions related to AMA events and calls for exploring opportunities for attendees to offset their environmental impact. While these resolutions highlight AMA's dedication to sustainability, it is also crucial to develop a comprehensive plan, considering all related implications and ensuring effective implementation. After initial research and consultation with relevant stakeholders, we are sharing an update on AMA's progress towards achieving carbon neutrality within our AMA and encouraging similar efforts within the broader health care system. Below is a summary of our findings and the next steps.

Net Zero Emissions for Business Operations by 2030

AMA is committed to progressing towards reaching net zero emissions for business operations by 2030, by continuing to execute against the current initiatives and expanding upon them. Our team has already begun implementing measures to reduce our carbon footprint, including but not limited to:

Renegotiating the Chicago headquarters' lease with a LEED-Gold certified building and advocating for sustainable practices with our corporate partner vendors.

Making multiple energy efficient upgrades within our facilities:

New HVAC systems (including Merv-13 filtration) were added on each floor, resulting in a 35 percent energy reduction.
Lighting retrofits, including adding LEDs and a daylight harvesting feature in the lobby to automatically dim the lights according to the amount of sunlight entering the building), produced a savings of two million kilowatt-hours per year, or 70 percent less energy.

Water conservation programs:

- A restroom retrofit to incorporate low-flow fixtures (e.g., toilets that use 1.60 gallons of water per minute (gpm), urinals at 1 gpm and faucet aerators at 0.5 gpm).
- A 20 percent energy savings by re-landscaping with low-water plants like native perennials and sedum.
- Adding meters on all hoses, and a green-roof water supply to monitor usage and detect leaks.
- 50 percent of AMA Plaza's roof houses a green vegetable garden, which not only reduces carbon dioxide emissions but also slows the amount of rainfall runoff that goes to Chicago's sewer system. The roof at AMA Plaza is also home to a vegetable garden and bee program, which harvests honey twice a year.

AMA utilizes a shuttlebus service, bike area, on-site Zipcars and scooter and hybrid vehicle parking: all of which contribute to nine metric tons of carbon emissions reduction (the shuttlebuses alone save an average of 65,000 pounds in carbon dioxide emissions per month).

AMA's HQ café sources local food and participates in the building's compost program, which collects 70 percent of its waste; AMA staff and visiting members/meeting attendees can charge their electronics using solar-powered benches in AMA plaza.

AMA reduced its waste generation (paper and otherwise) and implemented enhanced recycling programs.

Leadership has encouraged telecommuting and virtual meetings to minimize travel emissions.

Evaluating Feasibility of Carbon Offsets and Sustainable Meeting Practices

Investing in projects to increase AMA's energy efficiency can contribute to reducing AMA's carbon emissions at a relatively low cost. Partnering with vendors that use renewable energy sources can also offer a cost-effective way to offset carbon emissions, and we continue to explore new vendors who generate clean energy, displacing the need for fossil fuel-based electricity and effectively reducing overall carbon emissions.

Leadership in Energy and Environmental Design (LEED) is the world's most widely used green building rating system, providing a framework for healthy, efficient, cost-effective buildings offering environmental, social, and other benefits. The AMA has tenancy in three locations (Chicago, DC, and Greenville) that have implemented varying sustainability best practices including LEED Green Certification, light sensors, recycling, etc. within their building guidelines. The AMA also instituted a requirement to contract exclusively with LEED-certified conference centers for Annual and Interim meetings in 2030. The Annual and Interim meetings have been contracted through 2029 with Hyatt and Marriott: AMA has committed to Hyatt Regency Chicago, a LEED-certified building, for AMA's Annual meeting through 2029; Hyatt's World of Care program is committed to advancing environmental action. AMA has contracted with Marriott properties through 2029 for Interim meetings; Marriott is integrating sustainability across their properties and is committed to mitigating climate-related risk, reducing environmental impact, building and operating sustainable hotels and sourcing responsibly (Gaylord National Resort and Convention Center in National Harbor, Maryland, recently announced a partnership with Unison Energy to commission a six-megawatt combined heat and power system to reduce its carbon footprint).

AMA is also pleased to announce that the forthcoming 2027 and 2029 Interim Meetings will be held at the prestigious Gaylord Pacific, currently under construction. Gaylord Pacific is being meticulously designed to adhere to California's stringent energy code Title 24, surpassing even the standards set by LEED certified buildings. The project incorporates all coastal development mandates, positioning it as one of the most sustainable hotel and resort destinations in the United States; this commitment to environmental sustainability aligns seamlessly with the AMA's values and underscores our dedication to hosting events that prioritize sustainability and environmental stewardship.

CONCLUSION

In conclusion, the AMA is committed to continuing to execute against our current initiatives, and expanding upon them, to achieve environmental sustainability. These resolutions reflect our proactive stance in reducing carbon emissions and championing sustainability initiatives within our organization and the broader health care sector. Through our efforts, we demonstrate our dedication to mitigating the environmental impact of our business operations. Additionally, our commitment to limiting carbon emissions generated by AMA events and researching opportunities for attendees to offset their environmental impact, highlights our holistic approach to sustainability. Through these initiatives, the AMA reaffirms its commitment to environmental stewardship and welcomes the opportunity to drive meaningful change within the health care ecosystem and beyond.

RECOMMENDATION: The Board of Trustees recommends that the following be adopted in lieu of Resolutions 603-A-23 and 608-A-23, and the remainder of the report be filed:

1. Our AMA is committed to progression to net zero emissions for its business operations by 2030, by continuing and expanding energy efficiency upgrades, waste reduction initiatives, and the transition to renewable energy sources.
2. Our AMA will prioritize sustainable organizational practices to reduce emissions.
3. Our AMA Board of Trustees will present a report at the 2024 Interim Meeting that details a timeline as to when and how to achieve our organizational carbon neutrality.
4. Our AMA will continue to prioritize collaboration within the health care community by sharing the learnings from our sustainability initiative to inspire our peer organizations to follow suit and adopt similar environmentally conscious practices
5. Our AMA will work with appropriate entities to encourage the United States healthcare system to decrease emissions to half of 2010 levels by 2030, achieve net zero by 2050, and remain net zero or negative.

26. EQUITY AND JUSTICE INITIATIVES FOR INTERNATIONAL MEDICAL GRADUATES

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATION ADOPTED
REMAINDER OF REPORT FILED

BACKGROUND

At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 605-A-23, "Equity and Justice Initiatives for International Medical Graduates[1]," sponsored by the International Medical Graduates Section, was referred to the Board of Trustees. Resolution 605-A-23 requested:

1. That our American Medical Association, via the Center for Health Equity, create a yearly session (during the Interim or Annual Meeting) as a part of the equity forum that will be dedicated to international medical graduates (Directive to Take Action); and

2. That our AMA, via the Center of Health Equity, create an amendment to the health equity plan that will address the issues of equity and justice for international medical graduates. (Directive to Take Action)

DISCUSSION

This report seeks to provide clarity to two questions: (1) Whether the AMA should, via the Center for Health Equity, create a yearly session (during the Interim or Annual Meeting) as part of the equity forum that will be dedicated to international medical graduates; and (2) Whether the AMA should, via the Center for Health Equity, create an amendment to the health equity plan that will address the issues of equity and justice for international medical graduates.

AMA Health Equity Open Forum

In 2022, at the Annual Meeting, the HOD adopted new policy titled “Continuing Equity Education G-600.960”, which instructed AMA to establish an Open Forum on Health Equity, to be held at least annually at a House of Delegates Meeting, for members to directly engage in educational discourse and strengthen organizational capacity to advance and operationalize equity.
Prior to its adoption, Resolution 611-A-22, as it was known at the time, was discussed openly during the Reference Committee F Hearing. The resulting committee report provided:

> Reference Committee heard supportive testimony acknowledging the importance of prioritizing equity through forums, education sessions, and other programming. Testimony supported changing the frequency of educational opportunities to each House of Delegates meeting, noting that it will increase education and awareness of the effects of bias, prejudice, and racism in medicine. During testimony, it was mentioned that a call for education sessions is made prior to each House of Delegates meeting. For the June 2022 meeting, the Center for Health Equity opted to host education sessions in lieu of an open forum. Format and timing of educational sessions at the House of Delegates is at the discretion of the Speakers in consultation with subject matter experts. In addition, the proffered language allows for the potential of additional sessions offered online, asynchronous to the House of Delegates meeting, or even at other AMA sponsored meetings.[2]

The report provides many details, but it appears that delegates and attendees did not discuss specific subject matter to be presented at each open forum, subsequently leaving the policy open to interpretation. This is not an uncommon practice, if one were to skim through AMA policy, they would find that many organizational policies have been adopted in the same manner relying on staff experts to take the lead on executing requested actions.

If we can infer anything from the HOD’s decision to adopt the policy on Continuing Equity Education with its current language, it would be that the HOD reserved the task of making equity-based decisions on content development for the open forum for AMA staff. Since the policy was adopted at the 2022 Annual Meeting, the Center for Health Equity has taken the lead on planning and has successfully hosted two forums. During the planning and development stages, staff consistently prioritizes equity by ensuring diverse perspectives are represented; considering the unique needs and experiences of all potential attendees to create inclusive content that resonates with a wide audience; focusing on time-sensitive topics to operationalize equity; and regularly assessing and adjusting their approach to address any disparities and promote fairness in the planning and development process. To permanently designate a particular topic or group over others would be counterproductive to the ideals of fairness and equity and risks the possibility of harm, creating an atmosphere of resentment and discouragement among those who may feel excluded or unfairly treated. Instead, AMA staff has employed an equitable content planning and development process that balances the consideration of competing recommendations. Since policy does require an equity forum at least once a year, each meeting presents an additional opportunity to educate the House on a variety of equity-based topics, which can include, but is not limited to, issues related to IMGs.

AMA Strategic Plan to Embed Racial Justice and Advance Health Equity

In 2021, the Center for Health Equity published the AMA Strategic Plan to Embed Racial Justice and Advance Health Equity. The 86-page document is a comprehensive initiative aimed at addressing systemic inequities in healthcare. Rooted in the recognition of historical injustices and social drivers of health, the plan outlines strategic actions to promote equity, diversity, and inclusion within the medical community. It emphasizes the need for culturally competent care, increased representation of minoritized and marginalized individuals in healthcare leadership, and the dismantling of barriers that perpetuate racial and ethnic disparities. The Strategic Plan has sought to accomplish many goals, but the document was also scheduled to sunset in 2023. To continue the work that the first Strategic Plan initiated, the AMA has pushed forward with the development of the next iteration of the Plan. Following the goals outlined in the first Strategic Plan, the second plan will go further by highlighting IMGs specifically, their potential for advancing health equity amid significant challenges in training and working within the U.S. It will also include details related to recent policy developments, accomplishments, and a call to action for AMA. Prior to its release, authors of the Plan have worked closely with AMA IMG Section leadership to thoroughly review and ensure that IMG perspectives are prominent in the document. At the 2024 Annual Meeting, the Health Equity Open Forum will be an overview of the 2024-2025 Strategic Plan with designated time to focus on IMG issues and perspectives. Our AMA will continue to support IMGs by advocating for fair and transparent processes in licensing, protection of all rights and privileges, and recognizing the valuable contributions IMGs make to the U.S. health care system.

RECOMMENDATION

The Board of Trustees recommends that Resolution 605-A-23 not be adopted and that the remainder of this report be filed

REFERENCES.

1 Resolution 605-A-23, "Equity and Justice Initiatives for International Medical Graduates." https://www.ama-assn.org/system/files/a23-605.pdf
22022 Annual Meeting Reference Committee F Report. https://www.ama-assn.org/system/files/a22-reference-committee-reports.pdf

27. AMA REIMBURSEMENT OF NECESSARY HOD BUSINESS MEETING EXPENSES FOR DELEGATES AND ALTERNATES

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATION ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy G-600.003

At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD) Resolution 606, "AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates" was referred to the Board of Trustees for a report back to the HOD. The reference committee heard mixed testimony, including compelling testimony from the Board of Trustees regarding their fiduciary responsibility to our AMA and the need to allow sufficient time to identify and fully assess the impact on our AMA.

Resolution 606 asked:

> That our American Medical Association develop a reimbursement policy consistent with established AMA travel policies for reasonable travel expenses that any state or national specialty society is eligible to receive reimbursement for its delegate's and alternate delegate's actual expenses directly related to the necessary business functions required of its AMA delegates and alternate delegates in service to the AMA at HOD meetings, including travel, lodging, and meals; and
>
> That each state or national specialty society requesting such reimbursement for its delegate's and alternate delegate's reasonable travel expenses will submit its own aggregated documentation to the AMA in whatever form is requested by the AMA.

BACKGROUND

Resolution 606 highlighted the significance of the AMA HOD as a policy making body with diverse voices being represented through the delegations. The resolution focuses on the costs that are incurred by the organizations sending delegates and alternates to the meetings without discussing the costs of the meeting to the AMA. The resolution pointed out that several state and specialty medical societies are facing financial hardships due to several factors, including declining membership. As these organizations are looking to cut costs, not sending the full delegations or alternate delegates to the AMA HOD meetings could be seen as a savings. In some instances, delegates pay their own expenses at AMA HOD meetings so they can be a part of the robust policy making process. In addition, medical students and residents expressed issues with obtaining funding and are seeking inclusion in the development of an AMA reimbursement policy.

Costs

A fiscal note of $8.1 million was the estimate of the ongoing additional annual costs that would be incurred by the AMA if this resolution were adopted. This would be in addition to the $12 million the AMA is spending already to

hold HOD meetings and provide staff support for councils, sections and special groups. That does not include costs related to responding to and implementing resolutions from the HOD.

While our AMA has experienced above normal operating income over the last several years due to a reduction in expenses during the pandemic office closures and a record number of open positions due to tight labor markets, it is expected that the Association will return to full employment and regular operations by 2024, with a reversion to normal budgeted income.

AMA Budget and Reserve Policies

In the early 2000's, AMA's financial picture was very poor evidenced by questions raised at the HOD about the long-term viability of the organization. The AMA Board took action in 2000 to implement financial policies that would provide for ongoing sustainable operations and programmatic activities for both the short-and long-term. The goal was two-fold: 1) ensure that AMA would be able to withstand short-term volatility in revenue without requiring elimination of programs or personal that would be harmful to AMA's reputation and 2) create reserve assets that could serve as a quasi-endowment fund to help ensure long-term fiscal stability of the organization. The annual budget policy was in answer to the first goal and that policy requires that AMA budget a surplus equal to the inflationary impact on two- to three-year's operating expenses. The reserve policy prohibits the use of reserves for ongoing operating expenses in order to avoid drawing down the reserves on an annual basis and thus impairing the ability to maintain and grow reserves for the long-term stability of the organization, i.e., AMA's quasi-endowment fund.

The two policies cited above mean that any expenditures above the current budget levels will require reducing expenses from other areas of the annual budget, i.e., other programmatic activities. If this resolution were adopted, that would result in an ongoing annual $8 million cost reduction in other programs, which at the current rate of inflation would cost almost $100 million over the next ten years. In addition, the size of the HOD continues to increase and this will drive total costs of delegates and alternate delegates attending in-person meetings higher than levels cited above, regardless of whether it is paid by AMA or the societies.

Financial and Tax Implications

AMA's tax-exempt status and the regulations under which it operates to maintain that status is a key consideration when determining if or how to provide benefits or contributions to individuals or organizations. As an example, AMA's tax counsel has advised that generally the IRS has found that the provision of financial benefits to members in certain situations will constitute private inurement which will result in the loss of tax-exempt status. Counsel did advise that the IRS has consistently viewed paying the reasonable travel expenses of volunteers, particularly those who participate in governance, as being acceptable and not treated as compensation which in this case would cover delegates and alternate delegates and thus led to the language of the resolution submitted to the HOD.

Additional discussions with tax counsel have resulted in another potential alternative, i.e., providing travel grants to societies in the HOD to cover or partially cover direct out-of-pocket expenses for delegates and alternate delegates based on financial need. Under this alternative, counsel recommended the following criteria:1) the travel grants be limited to societies that demonstrate financial need; 2) the travel grants should be specifically identified as grants to cover travel reimbursement only for voting delegates and alternate delegates who participate in the HOD meetings, enabling delegates to participate in discussions regarding important issues affecting AMA and the medical profession; 3) the grant agreement between AMA and the society should require that the funds are for reimbursement of incurred travel expenses in a manner that is consistent with 501(c)(6) purposes; and 4) that AMA should establish a cap on the amount that any one society can receive for reimbursement of travel expenses.

Based on the above alternative, AMA performed an analysis of the financial status of those societies seated in the HOD. The 2022 Form 990's submitted to the Internal Revenue Services were obtained for 178 constituent and specialty societies. Form 990's were not available for seven societies.

In 2022, the combined revenues and assets of the 178 societies total $3.2 billion and $7 billion respectively, and although there is wide disparity in the resources of these societies, is substantially more than AMA's revenue or assets. The estimated average cost of a delegate and alternate delegate attending the AMA meetings is approximately $11,400. At revenue levels of $2.5 million and above, the total average cost for delegates and

alternates would range from 0.04% to 2.1%. of annual revenue. In comparison, AMA currently spends 2.6% of its total annual revenue on HOD activities.

The AMA realizes the importance of representation and participation in the policy-making process and the strength of organized medicine, are the organizations who send representatives to our HOD meetings to participate in the policy making process. Your Board of Trustees presents this report as informational as we continue to study options for strengthening the participation of the Federation in House of Delegates meetings. Your Board will submit a report at the 2025 Annual Meeting.

RECOMMENDATION

1. The AMA Board of Trustees, with input from Federation medical society physicians and staff members, will present a comprehensive report at I-24 that presents options for reducing the costs of meetings and mechanisms to provide financial support (including reimbursement of necessary business expenses or grants) for Delegates and Alternate Delegates who are credentialed to participate in our House of Delegates.

28. ENCOURAGING COLLABORATION BETWEEN PHYSICIANS AND INDUSTRY IN AI DEVELOPMENT

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATION ADOPTED
REMAINDER OF REPORT FILED

INTRODUCTION

At the 2023 Annual Meeting, the House of Delegates (HOD) referred Resolution 609-A-23, "Encouraging Collaboration Between Physicians and Industry in Augmented Intelligence (AI) Development", for report back at the 2024 Annual Meeting. This resolution was introduced by the Medical Student Section and asked that our American Medical Association (AMA):

1. Augment the existing Physician Innovation Network (PIN) through the creation of advisors to specifically link physician members of AMA and its associated specialty societies with companies or individuals working on AI research and development, focusing on:

    a. Expanding recruitment among AMA physician members,
    b. Advising AMA physician members who are interested in healthcare innovation/AI without knowledge of proper channels to pursue their ideas,
    c. Increasing outreach from AMA to industry leaders and companies to both further promote the PIN and to understand the needs of specific companies,
    d. Facilitating communication between companies and physicians with similar interests,
    e. Matching physicians to projects early in their design and testing stages,
    f. Decreasing the time and workload spent by individual physicians on finding projects themselves,
    g. Above all, boosting physician-centered innovation in the field of AI research and development (Directive to Take Action); and

2. Support selection of PIN advisors through an application process where candidates are screened by PIN leadership for interpersonal skills, problem solving, networking abilities, objective decision making and familiarity with industry (New HOD Policy).

BACKGROUND

Artificial intelligence focuses on developing smart machines that can perform tasks that otherwise require human intelligence. Augmented intelligence (AI), a subsection of artificial intelligence, depends on machine learning (ML) techniques to extract large amounts of data to assist humans in solving problems.[1,2] It has been used within a wide array of fields and is responsible for innovations such as web search, targeted content and product recommendations and autonomous vehicles.[1] In 2016, AI projects within medicine attracted more investment than AI projects within

any other sector of the global economy.[3] AI applications within medicine include diagnostics, drug discovery and development, medical documentation and remote treatment. Several recent strides have been made in this area. For instance, Google developed and trained an AI model to classify images as diabetic retinopathy and macular edema for adult patients with diabetes, producing implications for improved detection, diagnosis and treatment of diabetic retinopathy. Additionally, companies have used ML algorithms to identify drugs that treat neurological diseases.[1]

The purpose of AI application to medicine is to supplement—not supplant—the work of health care practitioners and a misunderstanding of this concept is a major deterrent to the adoption of AI innovations by clinicians and health systems.[4] It is essential that physicians and members of their care teams are included across all stages of the development of AI innovations in health care so such designs best reflect what they find valuable for treating their patients and reducing administrative and other burdens. The integral role physicians play in the development of health care AI enables the refinement of clinical algorithms, testing of new clinical tools and research designed to improve disease management and outcomes.[5] However, research shows that current AI applications in health care may not sufficiently reflect that they've been designed with health care practitioners at the forefront. Despite physicians' desire to be consulted on tech decisions, many of them lack any significant influence on these decisions.[6]

It is especially important that efforts to include physicians in the development of health care AI are diverse and comprise marginalized and minoritized physicians so bias that underlies existing data is not further entrenched into AI solutions and health inequities are not exacerbated. Further, equitable inclusion of physicians in the research and development of AI is imperative to its success, as evidenced by literature on racial concordance in medicine. For example, a 2018 Stanford study illustrated how Black physicians were more likely to engage with Black men—a patient group with a historically lower life expectancy—and even collect consent to provide preventive services like cardiovascular screenings and immunizations.[7] Additionally, research found that a 10% increase in Black primary care physicians was associated with a 30.61-day increase in life expectancy and a decrease in all-cause mortality by 12.71 deaths per 100,000 among Black individuals.[8] Despite such statistics, only 5.7% of physicians in 2023 identified as Black.[9] AI can either improve the system by filling these gaps or inadvertently worsen current health inequities by reproducing and normalizing what exists. While increased application of AI in healthcare is expected to reduce bias and promote health equity by improving evidence-based interventions for marginalized and minoritized communities, the voices of these physicians must be integrated early and more often within the development of these tools to truly improve health outcomes for all patients.[10]

DISCUSSION

The AMA is committed to ensuring that AI can meet its full potential to advance clinical care and improve clinician well-being. As the number of AI-enabled health care tools continue to grow, it is critical they are designed, developed and deployed in a manner that is ethical, equitable and responsible. The use of AI in health care must be transparent to both physicians and patients, and positioning the physician voice front and center is critical.

AMA Physician Innovation Network (PIN)

To address concerns around the lack of the physician voice in health care innovation, the AMA launched the Physician Innovation Network (PIN) in 2016. Since then, the network has grown to over 18,000 users and continues to bring together physicians and health tech companies through its various offerings.

The PIN platform is available for all physicians to join and connect with other stakeholders across the innovation ecosystem including responding to opportunities posted by digital health and technology companies seeking feedback from subject matter experts. AMA's PIN "In Real Life" (IRL) events launched in 2022 with the purpose of bringing the online platform to life, encouraging companies to be transparent about their design challenges and hosting diverse physician voices to create an engaging, live PIN experience. Health tech conferences are not usually the events that most practicing physicians attend to advance their professional development. However, such a structure allows physicians to connect with companies live, share clinical problems and expertise and provide feedback on solutions being developed across the health care industry. The PIN IRL events will evolve this structure in an iterative fashion as we continue to evaluate physicians' needs in the changing technological landscape. Further, PIN Community Office Hours occur bi-weekly and provide an opportunity for subject matter experts across the PIN community to connect with digital health solutions focused on optimizing patient experience and minimizing physician burnout.

The AMA is engaging PIN Physicians to gather feedback and continue iterating on how to help bring better solutions to market together. All AMA members are invited to join PIN and should be ambassadors to their organizations about the platform's ability to link subject matter experts and solution designers. Companies developing health care solutions enabled by AI and ML are interacting on PIN. However, it is the individual physician member's decision how they would like to interact with each company. Some companies post paid opportunities while others are so early in their development that they only have volunteer opportunities posted. Additionally, the AMA is in conversations with the World Medical Association to expand the PIN to a global audience. Applying for PIN IRL engagements is one of the best ways to be involved. As we examine the successes of PIN and the current clinical technology needs of physicians, the PIN strategy is continuously re-evaluated to ensure the program's impact is maximized.

Advocacy

AI has been an area of focus for AMA advocacy for several years with the first set of advocacy principles developed in 2018. In addition to interfacing with medical devices, AI is increasingly used in health care administration and to reduce physician burden, and policy and guidance for both device and non-device use of health care AI is necessary. Recognizing this, the AMA developed an updated set of advocacy principles that builds on current AI policy. These new principles address the development, deployment and use of health care AI, with particular emphasis on:

- Health care AI oversight;
- When and what to disclose to advance AI transparency;
- Generative AI policies and governance;
- Physician liability for use of AI-enabled technologies;
- AI data privacy and cybersecurity; and
- Payor use of AI and automated decision-making systems.[11]

The AMA also continues to keep track of AI-related legislation and policy coming from both the congressional bodies, as well as the federal government.

Additionally, the AMA plans to research state-based AI policies to better understand local approaches to policy and regulation for the use of AI across health care stakeholders, including health care practices, health systems and payers.*AMA research, programs and other resources*

The AMA is committed to researching the AI landscape in health care and developing resources to support physicians in getting involved in the design, development and deployment of these tools across the industry. In 2023, the AMA completed a survey to better understand physician sentiments around AI, including opportunities, current use cases and needs around education and support for the implementation and use of AI. Of the 1,081 physicians surveyed, 41% responded that they were both equally excited and concerned about AI. It was also confirmed that physicians are seeking more information in digestible formats that can help them successfully evaluate and use these tools in their clinical environments.[6]

In February 2024, the AMA released a foundational AI landscape report as part of its Future of Health work titled, "The Emerging Landscape of Augmented Intelligence in Health Care". The report aims to create a common lexicon for augmented intelligence in health care, explore the risks, identify current and future use cases and provide guidance for physicians looking to leverage these tools in practice. As part of this research, the AMA completed the previously mentioned survey designed to capture physician sentiments around AI, held a set of one-on-one interviews with key stakeholders from across the industry and hosted a specialty society workshop to align on key priorities across specialties. The report lays the foundation for the development of additional educational content into specific areas of AI to further support the implementation and use of AI in practice including, but not limited to:

- Practical case studies of where AI is working in practice today.
- Issue briefs aimed at deciphering AI policy. For instance, the AMA released a guide in 2023, providing advice for physicians when considering ChatGPT.
- Research on areas where AI is impacting clinician well-being (i.e. documentation burden reduction, etc.).
- Step-by-step educational materials on creating governance structures that support the successful selection and deployment of AI solutions.

The AMA ChangeMedEd initiative works with partners across the medical education continuum to help produce a physician workforce that meets the needs of patients today and in the future. As part of these efforts, an Artificial Intelligence in Health Care learning series was recently published on the AMA EdHub. These modules are geared towards medical students and physician learners, and introduce key concepts related to artificial intelligence and ML in health care. These are developed in collaboration with medical education partners from across the nation.

Further, the AMA and Accreditation Council for Graduate Medical Education (ACGME) have a shared interest in fostering the use of AI to improve education across a physician's career. The ACGME is aware of the AMA's conceptual model of Precision Education and has participated in the AMA Accelerating Change in Medical Education Consortium's National Advisory Panel around planning the next major initiative. Awardees of AMA grant funding also presented their work on leveraging AI to improve residency selection and education at the 2024 ACGME Annual Education Conference.

Additionally, the AMA is engaged with the American Board of Medical Specialties, National Board of Medical Examiners, Association of American Medical Colleges, Association for Hospital Medical Education, International Association of Medical Science Educators, as well as several specialty societies, medical schools and academic health systems around advancing AI in medical education. AMA staff will also serve on the planning committee for the Macy Foundation's next conference which will focus on AI in medical education. These conferences are designed to generate national recommendations which are typically published in the journal, *Academic Medicine.*

The AMA has also crafted a framework to promote the development and use of responsible, evidence-based, unbiased and equitable health care AI. This ethics-evidence-equity framework envisions the use of AI to advance the quadruple aim (enhancing patient care, improving population health and clinician work-life and reducing costs) and defines the responsibilities of developers, health care organizations (deployers) and physicians to put the framework into action. For instance, the framework outlines the responsibility of all three groups to (1) develop a protocol to identify and correct for potential bias, as well as (2) ensure protocols exist for enforcement and accountability, including a system to ensure equitable implementation. Physicians can use the framework to assess if an AI innovation meets the qualifications for ethics, evidence and equity and can therefore be trusted.[12] This framework has also been leveraged to create a companion resource that considers educational applications of AI and addresses the use of AI to facilitate the process of training health professionals.

Further, the AMA is in the process of creating a physician development curriculum that will cover topics across physician leadership and the business of medicine. The goal of these materials is to empower and support physicians throughout their professional lives by amplifying AMA-wide resources on the health care landscape, leadership and the business of medicine and develop new resources where gaps exist. These materials will be made available for both individual physicians and member organizations.

Additionally, the AMA developed the CPT® Developer Program to assist developers in translating ideas into innovations. The program is dedicated to developers' needs and provides them with access to high-quality AMA CPT content and resources.

As interest grows in the use of AI solutions and tools that address administrative burden and support physicians in their daily tasks, the AMA is committed to ensuring that the evolution of AI in medicine equitably benefits patients, physicians and other health care stakeholders. The AMA intends to continue developing AI principles for the use of AI in health care, advocate for state and federal policies that ensure appropriate oversight and continued innovation in AI, partner with health and technology leaders to ensure physicians have a leading voice in shaping the ethical use of AI in medicine, promote training in AI across the continuum of medical education and provide high-value insights and actionable resources for physicians.

Stakeholder engagement

The AMA is a convener around many topics important to physicians including AI. As a follow up to the Specialty Society workshop in 2023, the AMA has created an AI Specialty Collaborative with over 15 specialty associations committed to participating. The goal of the collaborative is to ensure the physician voice is leading in a united way as AI in health care continues to expand. Additionally, this group will collectively identify priorities and collaboratively develop resources to advance AI in health care starting in the second quarter of 2024.

The AMA also continues to stay abreast of the latest developments in AI across the industry through participation in external industry collaboratives. For example, the AMA is currently a non-profit member organization of VALID AI, an execution accelerator dedicated to bridging the gap in coordinated efforts around generative AI while rapidly advancing validation and governance implementation.

Furthermore, as a member of the Health AI Partnership—a collaboration among 14 health care organizations and ecosystem partners—the AMA is encouraging the collaborative development and dissemination of AI best practices. The AMA will continue to work with this partnership and others to develop resources, including a case-based AI ethics training program that will delve into real-world, contemporary challenges that physicians and health care delivery organizations face when using AI.

The In Full Health Learning & Action Community to Advance Equitable Health Innovation initiative seeks to advance equitable opportunities in health innovation investment, solution development and purchasing. The AMA has partnered with founding collaborator organizations to support this community with content, tools, resources and opportunities to connect, engage and learn with and from each other to advance equitable health innovation.

The AMA also has long standing relationship with the innovation accelerator, MATTER. As part of this sponsorship, AMA employees and physician members have access to the MATTER space and programming. AMA physician members can also reach out to AMA staff contacts to learn more about getting involved with MATTER and other innovation accelerator programs.

Further, the AMA participated in a joint clinician panel with the Office of the National Coordinator for Health Information Technology in 2020 titled, "Artificial Intelligence in Health IT- The Good, The Bad, The Ugly" and continues to engage in additional conferences such as HLTH and ViVE, where AMA representatives engage in a variety of topics around health care technology including AI.

In addition to the efforts outlined above, the AMA has several internal cross-business unit workgroups in place to ensure alignment across the work in innovation and specifically, AI. There is a Future of Health workgroup meeting that occurs monthly to stay aligned on the latest policy, projects and collaborations in progress around innovation and digital health. Additionally, the Advocacy business unit convenes two monthly meetings specifically focused on aligning AI initiatives across the AMA.

AMA POLICY

As a leader in American medicine, the AMA has a unique opportunity to ensure that the evolution of AI in medicine benefits patients, physicians and the health care community. The AMA has several policies in place around ensuring the physician voice is reflected in the design and development of AI innovations in health care.

The AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
    a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
    b. is transparent;
    c. conforms to leading standards for reproducibility;
    d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
    e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI (Policy H-480.940, "Augmented Intelligence in Health Care").

The AMA also supports the use and payment of AI systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy and equity including addressing bias; AI system methods; level of automation; transparency; and conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.
4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness and standards of care are in flux. Furthermore, our AMA opposes:
    a. Policies by payers, hospitals, health systems or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
    b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation and implementation. Our AMA will further advocate:
    a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
    b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. The AMA, national medical specialty societies, and state medical associations—
    a. Identify areas of medical practice where AI systems would advance the quadruple aim;
    b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;
    c. Outline new professional roles and capacities required to aid and guide health care AI systems; and
    d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it (Policy H-480.939, "Augmented Intelligence in Health Care").

CONCLUSION

The AMA has various existing initiatives, research, policy, advocacy efforts, educational material and other resources that are aligned with the desire to boost physician-centered innovation in the field of AI research and development. As such, much of the work that Resolution 609-A-23 asks the AMA to conduct is already ongoing.

The PIN serves as one source of connecting physicians with innovative companies, specifically those working in the AI space. With that said, as noted, the PIN is undergoing a strategic review and updates to maximize its impact to physicians in decreasing the burden of clinical technology. As we continue to evaluate PIN, we will consider the significance of factors such as AI and other evolving technologies to the practice of medicine and incorporate them into our approach to PIN. At this time, the timing and approach are not aligned to create any specific workgroup linked to PIN.

The costs associated with identifying, establishing and convening a formal advisory board to facilitate relationships between physicians and the AI industry are significant. Additionally, the existing engagement and collaboration the AMA has across initiatives from physicians, specialty and state society and association stakeholders and industry allows AMA to obtain more diverse perspectives and experiences than a formal advisory board. The AMA continues to ensure the AMA is inclusive and equitable in its approach to research, advocacy and education.

RECOMMENDATIONS

The Board of Trustees recommends that Resolution 609-A-23 not be adopted and that this report be filed.

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29. TRANSPARENCY AND ACCOUNTABILITY OF HOSPITALS AND HOSPITAL SYSTEMS

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies D-375.987, H-200.971, H-225.950, H-225.952, H-230.965, H-375.960, H-375.962, H-405-950 and H-435.942

INTRODUCTION

At the 2023 Annual Meeting, the House of Delegates (HOD) adopted Policy D-200.971, "Transparency and Accountability of Hospitals and Hospital Systems." This resolution asked that our American Medical Association (AMA) (1) identify options for developing and implementing processes – including increased transparency of physicians complaints made to the Equal Employment Opportunity Commission (EEOC) and The Joint Commission – for tracking and monitoring physician complaints against hospitals and hospital systems and (2) report back with recommendations for implementing such processes, including potential revisions to the Health Care Quality Improvement Act (HCQIA) of 1986 to include monetary penalties for institutions performing bad-faith peer reviews.

BACKGROUND

Key issues raised by the resolution that resulted in Policy D-200.971 were (1) the perceived limitations for physicians to safely, and without fear of retaliation, report patient care concerns due to the large influence and market dominance many health systems have; (2) mistreatment of or retaliation against physicians who report concerns, including through the conduct of bad-faith peer reviews; (3) the lack of publicly available information about complaints against hospitals and health systems; and (4) the potential amendment of the HCQIA to add monetary penalties for entities found to have conducted bad-faith peer reviews. Testimony in the Reference Committee hearing on this resolution also indicated that access to information about complaints filed on health systems would be valuable to physicians considering new employment. This report will address these items, in addition to brief background on peer reviews and the HCQIA, and make recommendations for further HOD action.

DISCUSSION

Whistleblower reports

Physicians or other medical professionals may have the unfortunate experience of witnessing unethical behavior, an incident where a patient was harmed or a colleague committing some type of wrongdoing. Upholding the ethical standards of the profession is among the duties of all health care professionals, and part of fulfilling that duty includes reporting concerns and issues when they happen. Hospitals and health systems, who depend on high quality ratings and safety scores, as well as low numbers of safety violations, do not always receive these reports well. Althoughunlawful, since whistleblowers are protected by dozens of laws, people who report complaints or concerns, or "whistleblowers," may be ostracized, pressured to withdraw their report or threatened with counter allegations. Worse, a hospital may turn against the complainant and punish them through other means of retaliation such as a false or fabricated peer review. Given the potential negative consequences, many health care workers may avoid reporting ethical or patient safety concerns out of fear for their own livelihood, safety or reputation.[1]

Peer review

When a patient-safety or ethical violation is investigated, peer reviews are often the mechanism for evaluating the circumstances, conduct and outcomes of the incident. Peer review processes are long-established within organized medicine, intended to ensure patient safety but also to scrutinize professional conduct and protect hospitals from liability.[2] The responsibility to ensure quality care through physician monitoring has been delegated to committees composed mainly of medical staff that review physician credentials and applications for admission to the medical staff, as well as determine the privileges physicians have at a hospital.[3] Peer review is recognized and accepted as a means of promoting professionalism and maintaining trust. The peer review process is intended to balance physicians' right to exercise medical judgment freely with the obligation to do so wisely and temperately.[2]

The AMA defines peer review, in part, as: "… the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice…" Peer review goes beyond individual review of instances or events; it is a mechanism for assuring the quality, safety and appropriateness of hospital services. The duties of peer review are addressing the standard of care, preventing patient harm, evaluating patient safety and quality of care and ensuring that the design of systems or settings of care support safety and high quality care (Policy H-375.962, "Legal Protections for Peer Review").[4]

This policy continues to discuss a "good faith peer review": a "peer review conducted with honest intentions that assess appropriateness and medical necessity to assure safe, high-quality medical care is good faith peer review. Misfeasance (i.e., abuse of authority during the peer review process to achieve a desired result other than improved patient care), or misuse of the peer review process, or peer review that is politically motivated, manipulated to achieve economic gains or due to personal vendetta is not considered a good faith peer review".[4]

Health Care Quality Improvement Act of 1986

The HCQIA of 1986 was introduced to provide protection from liability under federal and state laws for members of a professional review body and their staffs, and establish a national repository for reported information regarding medical malpractice payments and adverse actions involving physicians.[5]Since then, each state (and the District of Columbia) have passed their own laws requiring the peer review process to improve health care quality.[3]

In addition to establishing the National Practitioner Data Bank (NPDB) to monitor hospital- and state-level credentialing of physicians, the HCQIA also granted federal immunity protections to physicians that participate in good faith evaluation of their peers. To qualify for immunity protections under the Act, it is presumed that the actions of peer review committees meet four standards, unless their actions are rebutted by a "preponderance of the evidence", wherein the burden of proof is on the physician undergoing review.[3,6] First, there must be a reasonable belief that peer review action was taken to ensure quality care. Second, peer review action should only be taken after a reasonable effort to obtain the facts surrounding the case. Third, the physician undergoing peer review must be afforded sufficient notice and hearing procedures or other fair protocols relevant to the circumstances of the case. Last, after reasonable efforts to obtain the facts of the case have been made, reasonable belief that peer review action was warranted by these facts is then also required.[3]

Bad-faith peer review

Because peer review committees are typically not independent, and often comprise hospital-employed physicians who have agreed to make decisions on behalf of the organization, judgments made by these committees have the potential to be biased. A bad-faith, or "sham" peer review, may be politically motivated, manipulated to achieve economic gains or to avoid financial risks, conducted in a way that helps the organization avoid reputational damage or is facilitated to fulfill a personal vendetta against an individual. The peer review process may also be exploited to deem the whistleblower incompetent or disruptive, undermining the merits of their report. Such inappropriate peer reviews were the subject of AMA Board of Trustees Report 24-A-08, titled "Inappropriate Peer Reviews," which described several cases of improperly motivated peer review, including *Patrick v Burget* (1998), *Rosenblit v Superior Court (*1991), *Clark v Columbia/HCA Information Services* (2001), and *Poliner vs Presbyterian Hospital of Dallas* (2006).[7]

Victims of bad-faith peer reviews often share similar characteristics that cause them to be perceived as "easy targets." Such characteristics include independent physicians that lack the social and political support and other resources frequently enjoyed by physicians who are part of large health systems, physicians who are new on staff

and haven't yet had the opportunity to develop strong connections and physicians that perform "new" or "different" procedures.[3]

Racial inequities in adverse action reports

Anecdotal evidence from the media and health law bar have reported a rise in racial inequities in adverse medical staff actions. This increase is believed to be due to racially motivated actions and more physicians of color challenging such actions. One example of this involved a Black physician who, over the course of 25 years, resided in a rural community, established a practice, and maintained an honorable career in her specialty. After identifying an unmet need of a patient population in her rural community that went unaddressed by local health systems, she established an outpatient facility that thrived. After she brought forward quality of care concerns regarding the danger to high-risk patients created by a gap in specialty coverage and quality nursing care at the hospital, a medical staff investigation was initiated against her by the hospital's peer review committee in response to retaliatory nursing staff claims. To avoid a potentially career-ending report to the NPDB, the physician was forced to invest time, money and energy toward participation in the demoralizing, retaliatory medical staff investigation.[6]

Adverse medical staff actions that cite subjective reasons such as "disruptive" behavior, competency concerns and/or unprofessional conduct have served to justify racism against Black physicians and other minoritized physicians. Racially motivated bad-faith peer reviews threaten the economic and mental well-being of physicians of color in addition to the health outcomes of the diverse patient populations they care for.[6]

Some hospital- and health system-level recommendations that have been proposed to prevent racial discrimination in the peer review process include hiring racially diverse leadership, as well as representation on peer review committees and reviewing and revising peer review protocols through an equity lens.[6]

Perceived barriers to reporting patient care concerns

The authors of AMA Policy D-200.971 raised concerns about perceived barriers for physicians to report patient care or other concerns without fear of retaliation due to the large influence and market dominance many health systems have. AMA Board of Trustees Report 5-I-17, "Effective Peer Review", discussed this issue, addressing physicians' concerns with the waning influence or control they have over their employment or patient care, as they are increasingly becoming employed by or affiliated with large hospital systems or health care organizations.[8] Despite BOT Report 5-I-17 having been published more than six years ago, the issues addressed within it remain relevant and thus appropriate to cite within this current report.

"In a large health system or hospital, peer review systems are integral to safeguarding patient safety and care. Because peer review can involve close scrutiny of all aspects of patient care and safety, both with respect to organization-wide patient care and safety issues and issues concerning individual physicians and health care practitioners, the peer review process may bring to light serious patient care and safety issues that are systemic to a hospital or other lay organization. Exposure of such issues could damage the hospital's or organization's reputation in its community or its other business interests. Consequently, a physician may be reluctant to participate in a peer review proceeding for fear of retaliation if the physician believes that the hospital or lay organization will take issue with the result of, or the physician's role in, that proceeding. This fear is exacerbated if the hospital or lay organization dominates the physician's community. Thus, to ensure effective peer review, physician peer review participants must be protected from the possibility of retaliation".[8]

Physician concerns about retaliation against physician peer review participants have grown as hospitals employ more physicians and hospital markets become more concentrated. Many communities in the United States are dominated by only a few hospitals, or even by a single hospital. As more physicians have become employed by, or affiliated with, dominant hospitals or other powerful lay organizations, some physicians increasingly fear retaliation for expressing patient safety or care concerns during a peer review proceeding, or otherwise participating in a peer review process, that the hospital or organization perceives as being contrary to its financial interests.[8]

Existing mechanisms for reporting complaints or concerns

To understand the issue of the perceived limitations for physicians to safely report patient care concerns due to the large influence and dominance of their health systems and/or seek recourse if they believe a peer review process has been initiated against them based on unfounded, unfair allegations, we evaluated the landscape of reporting

mechanisms currently in place. Numerous systems exist for physicians to report complaints about a peer, patient safety concerns within their health system or other unethical or egregious practices they experience or observe within their place of practice. These systems are in place at multiple levels to promote patient safety and typically great efforts are made to ensure reports are confidential, so individuals feel safe and confident in reporting concerns without fear of retaliation.

The most appropriate organization for a physician to file a complaint against a health care system or hospital is their state medical board. Each state has at least one medical board that licenses allopathic or osteopathic doctors, investigates complaints, disciplines physicians, and refers physicians for evaluation and rehabilitation when appropriate.

Health care organizations should have in place reporting mechanisms through which physicians or other professionals can confidentially submit concerns or complaints without fear of recourse or retaliation. While this may be reasonable for expressing concerns about one's peer or colleague, due to concerns about privacy or fear of consequences many physicians may not feel comfortable bringing organization or system-level issues to their organization's leadership.

If physicians do not feel comfortable reporting concerns directly to their leadership or organization, they may report concerns or complaints about their health system or hospital to The Joint Commission if the organization is accredited or certified by The Joint Commission.[9] The Joint Commission's standards require leaders to provide and encourage the use of systems for blame-free reporting of a system or process failure. The Joint Commission encourages practices to engage frontline staff in internal reporting in a number of ways including (1) creating a nonpunitive approach to patient safety event reporting, (2) educating staff on and encouraging them to identify patient safety events that should be reported and (3) providing timely feedback regarding actions taken on reported patient safety events.[10]

The U.S. Department of Health & Human Services (HHS) provides a mechanism for physicians employed by HHS or one of its agencies, or whose employer receives HHS contract or grant funding, to have their whistleblower retaliation complaints processed by HHS-Office of the Inspector General. The actions of these physicians to expose unlawful activities such as abuse and mismanagement within an HHS agency, (sub)contractor or (sub)grantee organization are protected by HHS.[11] Individuals that submit a complaint can choose whether to provide identifying information or remain anonymous.[12]

Also at the federal level, if a physician has been unfairly subjected to a peer review due to underlying racial discrimination or denied compensation or benefits following a bad-faith peer review, for example, they can report such violations to the U.S. Department of Labor (DOL). The agency within the DOL that handles whistleblower retaliation allegations is the Occupational Safety and Health Administration (OSHA). OSHA enforces the retaliation protections of more than 20 federal laws.[13]

If a physician believes they have been subjected to a bad-faith peer review in retaliation for making complaints about discriminatory behavior, disclosing violations of the law, fraud, or abuse, refusing to obey an order believed to be discriminatory or participating in discrimination or whistleblower proceedings, one resource available to them for recourse is the EEOC.[14,15] A physician in this circumstance must provide evidence that (1) they participated in a protected activity, (2) their employer took materially adverse action and (3) retaliation was the driving force behind the employer's adverse action. Employer retaliatory action is any action that might deter a reasonable person from engaging in protected activity.[14]

Two additional resources that may be beneficial to physicians harmed by a bad-faith peer review are the Association of American Physicians and Surgeons (AAPS) Sham Peer Review Hotline and the Center for Peer Review Justice. Physicians can call or email the AAPS hotline for an attorney referral – a free resource for AAPS members.[16] The Center for Peer Review Justice offers complimentary second opinions, legal services, lectures and consultations regarding the NPDB.[17]

Lack of publicly available information about complaints against hospitals and health systems

There are no publicly available universal repositories that house information about U.S. physician or hospital misconduct, sanctions, malpractice incidents or other complaints. Some entities collect and track these elements, but none provide large-scale searchable tools for the public or for physicians seeking information about health systems

or hospitals. Most, if not all, states protect the confidentiality of peer review information, meaning that peer review information, documents and records cannot lawfully be disclosed to anyone except those conducting the peer review and any other specific individuals or entities identified in the peer review statute.[8] Here we describe the available resources and their respective access levels.

The Joint Commission does not publish information about complaints, but its publicly available Quality Check reports provide an indication of accreditation and quality performance. These reports could be accessed by a physician looking to verify an organization's accreditation status and quality reports before considering employment. The Quality Check reports published by The Joint Commission could serve as a publicly accessible channel in which to publish final determinations of physician complaints against hospitals and hospital systems.

Complaints to the EEOC are confidential and maintained for record-keeping purposes, as well as to determine if the situation is covered by the EEOC, unless and until an individual files a discrimination charge. After a charge is filed, the individual's name and basic information surrounding the allegations are released to their employer. However, by law, this information is not available to the public. Different protocols apply to federal employees.[18]

Individuals seeking information about a hospital or health system's involvement in malpractice cases have the right to access public records through the federal, state or county court systems. Typically, the public-facing systems provide basic information about cases, and do not disclose information about proceedings or outcomes. More detailed court records may be accessible by the public for a fee. These systems only demonstrate legal actions involving individuals or businesses, however, and are not necessarily an indication of a hospital's quality or a physician's medical competence. It is not recommended public court records be used as a basis for making employment decisions.

State licensure and hospital credentialing entities require reporting of disciplinary investigations and related actions on applications and renewal forms, which may include peer review committee investigations. The NPDB collects and maintains information reported by the states and hospitals including adverse licensure, professional review actions, clinical privileges actions, and medical malpractice actions. It is the only federal database containing information about physician malpractice, but the lack of contextual information about individual cases makes it an incomplete and potentially misleading resource. The NPDB does not track and publish individual complaints about health care organizations, health systems or other health care employers. The NPDB provides access about individual practitioners only to authorized users, such as hospitals and medical boards, but not the general public.[19] Since its inception, there have been multiple attempts from members of Congress and other stakeholders to make the NPDB public.[20–22]

Of note, the AMA has historically maintained opposition of attempts to make the NPDB available to the public, instead supporting state-level efforts and the Federation of State Medical Boards (FSMB) Physician Data Center (Policy H-355.975, "Opposition to the National Practitioner Data Bank").[23]

The FSMB Physician Data Center collects information reported from state medical boards, government regulatory entities, and international licensing authorities. Hospitals and health care organizations, not the public, can search licensure history and past regulatory actions, including revocations, suspensions, loss of license, probation restrictions and licensure denials, for actively licensed physicians.[24]

State medical boards provide the public with access to information about physician licensure status. Many, if not most, also include general information about whether a physician has had disciplinary action against them. These systems do not publish information about health care organizations.

Amending the HCQIA to mandate monetary penalties for bad-faith peer reviews

Policy H-200.971 recommends amendments to the HCQIA to impose monetary penalties for institutions performing bad-faith peer reviews. Similarly, proposals for the imposition of monetary penalties against hospitals that fail to report adverse actions to the NPDB have been attempted but not adopted.[25] Some states impose financial penalties on hospitals for failure to report physician misconduct, but they are reportedly difficult to enforce due to lack of resources for investigations and a tendency for the state medical board to investigate the individual physician rather than the entity that failed to report the incident.[25,26]

Sham peer reviews are difficult to identify, prove, and track. The burden of proof lies with the complainant, and it is challenging to acquire tangible proof that a hospital acted maliciously in conducting a peer review. If an organization is found to have participated in or conducted a bad-faith peer review, it is no longer protected by the immunity the HCQIA otherwise offers these entities. It is thus subject to exposure to lawsuits, claims for damages and the risk of very costly rulings.

Your Board of Trustees does not at this time recommend pursuing a HCQIA amendment strategy because doing so could result in significant, negative unintended consequences, especially with respect to the NPDB. Opening the law for amendment to mandate monetary penalties for health care organizations could present opportunities for parties, whose interests are not aligned with those of organized medicine, to reintroduce changes that have in the past been attempted. For example, stakeholders outside organized medicine have strongly urged Congress to amend the HCQIA so that the information in the NPDB would be publicly available. AMA opposes such efforts. For example, AMA Policy H-355.976, "National Practitioner Data Bank" states in part: "Our AMA: (a) opposes all efforts to open the National Practitioner Data Bank to public access; (b) strongly opposes public access to medical malpractice payment information in the National Practitioner Data Bank; and (c) opposes the implementation by the National Practitioner Data Bank of a self-query user fee." The AMA has taken this position because information in the NPDB is often incomplete and inaccurate, not organized in a way that patients will understand and is thus highly likely to be misunderstood or misinterpreted by patients. For these reasons and those previously mentioned, the Board does not recommend attempting to amend HCQIA.

AMA POLICY

The AMA has numerous policies affirming its position supporting retaliation protections, including specifically in the context of peer review participation.

Our AMA: (1) opposes mandates from employers to supervise non-physician providers as a condition for physician employment and in physician employment contracts; and (2) supports whistleblower protections for physicians who report unsafe care provided by non-physicians to the appropriate regulatory board (Policy H-405.950, "Preserving the Practice of Medicine").

AMA policy states that physicians should be free to exercise their personal and professional judgment in advocating on any matter regarding patient care interests and that employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers for asserting these interests (Policy H-225.950, "Principles for Physician Employment"; Policy H-225.952, "The Physician's Right to Exercise Independent Judgement in All Organized Medical Staff Affairs").

Further, the AMA condemns any action taken by administrators or governing bodies of hospitals or other health care delivery systems who act in an administrative capacity to reduce or withdraw or otherwise prevent a physician from exercising professional privileges because of medical staff advocacy activities unrelated to professional competence, conduct or ethics (Policy H-230.965, "Immunity from Retaliation Against Medical Staff Representatives by Hospital Administrators").

Our AMA (1) supports whistleblower protections for health care professionals and parties who raise questions that include, but are not limited to, issues of quality, safety and efficacy of health care and are adversely treated by any health care organization or entity and (2) will advocate for protection in medical staff bylaws to minimize negative repercussions for physicians who report problems within their workplace (Policy H-435.942, "Fair Process for Employed Physicians").

AMA policy also states that entities and participants engaged in good faith peer review activities should be immune from civil damages, injunctive or equitable relief and criminal liability, and should be afforded all available protections from any retaliatory actions that might be taken against such entities or participants because of their involvement in peer review activities. This policy also defines a "good faith peer review", supports the confidentiality of peer review committee proceedings and opposes efforts to make these proceedings or any resulting decisions public or available via self-query (Policy H-375.962, "Legal Protections for Peer Review").

Moreover, the AMA monitors legal and regulatory challenges to peer review immunity and non discoverability of peer review records/proceedings and continues to advocate for adherence to AMA policy, reporting challenges to peer review protections to the HOD (Policy D-375.997, "Peer Reviewer Immunity").

Additional AMA policies call for fair and unbiased peer review procedures that enable due process for all participants.

In 2016, the AMA adopted policy directing it to study the current environment for effective peer review in order to update current policy to include strategies for promoting effective peer review by physicians and to consider a national strategy for protecting all physicians from retaliation as a result from participating in effective peer review (Policy D-375.987, "Effective Peer Review").

Additionally, the AMA published policy outlining appropriate peer review procedures that urge state medical associations to determine if additional state agency supervision of peer review is needed to meet the active state supervision requirement set forth by the Supreme Court, and that peer review procedures should, at a minimum, meet the HCQIA standards for federal immunity (Policy H-375.983, "Appropriate Peer Review Procedures").

The AMA also adopted guidelines for obtaining outside reviewers when a fair review cannot be conducted by hospital medical staff (Policy H-375.960, "Protection Against External Peer Review Abuses").

AMA policy encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care. services. The AMA supports this use of physician data when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all patients and is used to provide accurate physician performance assessments (Policy H-406.991, "Work of the Task Force on the Release of Physician Data").

However, the AMA opposes the requirement that peer review organizations and private accreditation entities report any negative action or finding to the NPDB (Policy H-355.975, "Opposition to the National Practitioner Data Bank"), advocates for amendments to the Freedom of Information Act to exempt confidential peer review information from disclosure under the Act, and supports appropriate efforts to prohibit discovery of information obtained in the course of peer review proceedings (Policy D-375.999, "Confidentiality of Physician Peer Review").

Finally, the AMA Code of Medical Ethics includes opinions related to physicians' right to report concerns about their peers or organizations, the peer review process, and protections against retaliation.

The AMA believes that physicians have mutual obligations to hold one another to the ethical standards of their profession. Peer review, by the ethics committees of medical societies, hospital credentials and utilization committees, or other bodies, has long been established by organized medicine to scrutinize professional conduct. Peer review is recognized and accepted as a means of promoting professionalism and maintaining trust. The peer review process is intended to balance physicians' right to exercise medical judgment freely with the obligation to do so wisely and temperately (Opinion 9.4.1 Peer Review & Due Process).

The AMA also believes that physicians who become aware of or strongly suspect that conduct threatens patient welfare or otherwise appears to violate ethical or legal standards should:

a) Report the conduct to appropriate clinical authorities in the first instance so that the possible impact on patient welfare can be assessed and remedial action taken;
b) Report directly to the state licensing board when the conduct in question poses an immediate threat to the health and safety of patients or violates state licensing provisions.
(c) Report to a higher authority if the conduct continues unchanged despite initial reporting.
(d) Protect the privacy of any patients who may be involved to the greatest extent possible, consistent with due process.
(e) Report the suspected violation to appropriate authorities (Opinion 9.4.2 Reporting Incompetent or Unethical Behavior by Colleagues).

AMA RESOURCES

The AMA, despite having an abundance of policy on the matter, has not published a significant number of resources to help physicians navigate the tumultuous processes of reporting concerns or being the subject of a peer review. Existing resources include the following.

The AMA's Principles for Physician Employment include principles for peer review and performance evaluations and state that employed physicians should be accorded due-process protections, including a fair and objective hearing, in all peer review proceedings.

For medical staff leadership, the AMA Credentialing Services offers a webinar entitled, "Medical Group Peer Review: Legal Issues and Possible Protections", that provides information about the importance of ensuring fair peer review proceedings to mitigate liability.

Finally, physicians can submit concerns or complaints about another physician or health professional to the AMA, although the AMA Code of Medical Ethics states that grievances against a medical professional who is believed to be acting unethically or not providing a certain standard of care should be directed to the state medical licensing board. The AMA will not investigate any complaints of misconduct or unethical behavior by physicians or health care organizations, nor does the AMA have legal authority or the proper resources to investigate individual cases.

CONCLUSION

The key issues underpinning Policy H-200.971 are the (1) perceived limitations for physicians to safely, and without fear of retaliation, report patient care concerns due to the large influence and market dominance many health systems have; (2) the conduct of bad-faith peer reviews or other mistreatment or retaliation against physicians that have reported concerns; (3) lack of publicly available information about complaints against hospitals and health systems; and (4) the potential amendment of the HCQIA to add monetary penalties for entities found to have conducted bad-faith peer reviews.

This report provides detailed information about multiple systems in place for physicians to report concerns about their health system or hospital employer. Despite the attempts to make these systems safe and confidential, and the fact that employed physicians are protected from retaliation by state and federal laws, there are often still barriers that prevent physicians from reporting concerns without fear of retaliation in some form and/or seeking adequate recourse if a bad-faith peer review process is initiated against them.

Peer reviews in medicine will continue to be a mainstay in ensuring safe and ethical patient care is provided by competent physicians. When conducted appropriately and according to acceptable standards, peer reviews are a valuable tool for the health care system. The conduct of bad-faith peer reviews, however, is morally, ethically and professionally abhorrent, and runs counter to everything that physicians and the practice of medicine stand for.

Also highlighted in this report are several entities that collect and publish data on physician licensure, malpractice payments, and disciplinary actions. None of the systems that house this data make it available to the public. To our knowledge, no systems are in place to track and publicly report malpractice information or complaints against hospitals or health systems. It has long been the position of the AMA that malpractice payment information should not be made public. And while AMA policy requires state medical boards report disciplinary action to the AMA and FSMB, it does not call for or endorse the public reporting of such information. Physicians have numerous other options for locating organization-related information when seeking new employment, and the AMA does not support efforts to require the AMA, FSMB, The Joint Commission or any state or federal entity to dedicate resources to providing this information to the public for the purposes of aiding job seekers in their employment decisions. It is also the AMA's position that providing the public with access to incomplete information devoid of context would invite more issues than it would resolve. The AMA does, however, support transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as The Joint Commission Quality Check reports.

Finally, we address the request for the AMA to recommend amendments to the HCQIA to impose monetary penalties on perpetrators of bad-faith peer reviews. The HCQIA provides protection for hospitals and peer review committees, so long as their peer reviews are conducted in a manner consistent with the law. They are no longer entitled to such immunity if it is found they participated in or led a bad-faith peer review. In the U.S., the justice system is in the position to facilitate the appropriate penalization of organizations faced with lawsuits and damages brought on by their participation in bad-faith peer reviews. Considering (1) that protection under the HCQIA is not provided to organizations failing to meet the HCQIA's four standards of professional review; (2) the AMA has historically opposed attempts to amend the HCQIA; and (3) monetary penalties at the state level have not resulted in

increased reporting or reduced incident rates, the AMA does not recommend new attempts to amend the HCQIA for the purposes of adding such penalties for organizations involved in bad-faith peer reviews.[25,27,28]

RECOMMENDATIONS

The Board of Trustees recommends:

1. The following policies be reaffirmed:
    a. Policy H-405.950, "Preserving the Practice of Medicine"
    b. Policy H-225.950, "Principles for Physician Employment"
    c. Policy H-225.952, "The Physician's Right to Exercise Independent Judgement in All Organized Medical Staff Affairs"
    d. Policy H-230.965, "Immunity from Retaliation Against Medical Staff Representatives by Hospital Administrators"
    e. Policy H-435.942, "Fair Process for Employed Physicians"
    f. Policy H-375.962, "Legal Protections for Peer Review
    g. Policy D-375.987, "Effective Peer Review"
    h. Policy H-375.960, "Protection Against External Peer Review Abuses"; and

2. That the following policy statement be adopted to supersede Policy H-200.971, "Transparency and Accountability of Hospitals and Hospital Systems,":
    a. The AMA supports and facilitates transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as the Joint Commission Quality Check reports to include periodic report back to the HOD with the first update to be given at A-25.
    b. The AMA will develop educational materials on the peer review process and advocate on behalf of doctors who have been subject to bad faith peer review, including information about what constitutes a bad-faith peer review and what options physicians may have in navigating the peer review process.

3. That the title of Policy H-200.971, "Transparency and Accountability of Hospitals and Hospital Systems," be changed to:
    a. "Transparent Reporting of Physician Complaints Against Hospitals and Health Systems"

4. That the remainder of this report be filed.

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30. PROPER USE OF OVERSEAS VIRTUAL ASSISTANTS IN MEDICAL PRACTICE

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies H-135.932, H-180-944, H-200.947 and H-385.951

At the 2023 Annual Meeting of the House of Delegates (HOD), Policy H-200.947, "Proper Use of Virtual Assistants in Medical Practice", was adopted. This policy directed the American Medical Association (AMA) to (1) support the concept that properly trained overseas virtual assistants are an acceptable way to staff administrative roles in medical practice (New HOD Policy), and (2) study and offer formal guidance for physicians on how best to utilize overseas virtual assistants in such a way as to ensure protections for physicians, practices, patient outcomes, and overseas medical staff (Directive to Take Action).

This report details guidance, considerations (e.g., equity, diversity and inclusion, business and compliance), opportunities and challenges regarding the appropriate use of overseas virtual assistants by medical practices. Additionally, relevant AMA policy is discussed. Based on this information, AMA identified the need for the creation and publication of educational materials for medical practices that provide guidance on how best to utilize overseas virtual assistants in a manner that protects physicians, practices, patients, and overseas medical staff.

BACKGROUND

Over the last two decades, health care organizations have increasingly outsourced administrative and certain clinical work – such as revenue cycle management, coding and billing, IT support and prior authorization tasks – to entities or individuals that reside in different time zones. Outsourcing, a business agreement in which an organization contracts out the procurement of products or services to an external firm, became widely used in health care during the early 2000s. Organizations pursue these arrangements with the goals of lowering administrative costs, raising productivity, and addressing workforce shortages. In 2017 alone, health care industry outsourcing grew by 36%.[1]

In addition to outsourcing, health care organizations also began using remote employees for administrative positions. Remote work is the practice of working from one's home or another space separate from the office. Medical practices adopted remote work for employees for several reasons, including office closures during the COVID-19 pandemic, limited working space within the medical practice, employee retention and satisfaction and decreased practice overhead costs.[1]

In recent years, there has been an evolution from remote employees to virtual assistants. While remote employees are employed by the practice directly, a virtual assistant is an independent contractor who provides administrative services to clients while operating outside of the client's office. As such, the individual can be located anywhere in the world, broadening the candidate options for companies. Virtual assistants can also include artificial intelligence in software used by medical practices. As this resolution is specific to human virtual assistants, this report does not consider artificial intelligence virtual assistants.[1]

The primary benefit of using virtual assistants in medical practice is to offload administrative duties to decrease physician workload and allow more time for patient care. Properly informed medical practices can successfully utilize overseas or domestic virtual assistants for nonclinical, administrative tasks, including but not limited to appointment scheduling and reminders, sending and receiving patient medical records, visit note dictation, prior authorization requests, charge entry, claim submission, claim control, and follow-up. Additionally, the use of overseas virtual assistants can have economic benefits for medical practices. For instance, virtual assistants can be hired for a set number of hours or tasks each week instead of hiring a full-time employee, lowering staffing costs for

the practice. They also typically have a lower hourly rate than those in the U.S. largely due to a lower cost of living in the countries they live.[2]
Medical practices seeking virtual assistants outside of the U.S. can utilize online job boards specific to the geographical area they would like to search. One example is OnlineJobs.ph, a job board that connects companies to virtual assistants located in the Philippines.[3] These online job boards facilitate the initial communication and interview process and provide employers with best practices for training virtual assistants located within the U.S. or overseas.

Business and Compliance Considerations

There are several business and compliance considerations that medical practices should review before hiring a virtual assistant, including employee classification, global labor protections, and HIPAA compliance standards. Virtual assistants classified as independent contractors are required to report their income for taxes and social contributions within their country on their own. In contrast, remote direct hires are employed by the practice and may require additional tax liabilities, withholdings and employee benefits depending on local labor laws where the individual lives. Medical practices should consult an accountant for any reporting requirements the practice has for virtual assistants classified as independent contractors.[4]

Securing private and confidential data is of the utmost importance, especially when working remotely. To protect sensitive data, health care organizations and medical practices that utilize virtual assistants should establish data protection protocols and obtain the appropriate consents from users.[5] The AMA has created several resources to guide medical practices through the process of securing patient health information, including guidance on Implementing a Work-From-Home Program, a tip sheet for Working from home during COVID-19 pandemic, a checklist for protecting office computers in medical practices against cyberattacks and technology considerations for working remotely. However, medical practices employing virtual assistants should still consult with their IT vendor to ensure the security of patient health information.

Equity, Diversity, and Inclusion Considerations

When considering using overseas virtual assistants, medical practices and health care organizations should prioritize equity, diversity, and inclusion. For example, it is important that practices and organizations verify the U.S. Dollar conversion to the currency used by the virtual assistant or employee to ensure fair and reasonable compensation.

Other considerations include the virtual assistant work schedule if there is a large time difference between in-office staff within the country the organization operates in and the country in which overseas virtual assistants live. This is essential to promote a healthy work environment.[1] For example, some medical practices and health care organizations outsource the entirety of their customer service operations overseas and also supply these services for 24-hours. Time zone compatibility between the medical practice and virtual assistant can impact employee health and quality of life. Night shift workers experience an incompatibility with family leisure time and the unavailability of services during nighttime hours.[6] These workers are prevented from recovering from a long day of work in the way that day shift workers can. Rather, when their shift ends, they must still function in a world operating on a completely different schedule. Studies have examined the social ramifications to this work. For instance, night shift workers have been demonstrated to experience divorce rates as high as 30 percent.[7] Health risks among night shift workers have also been analyzed. In a study of night shift employees working at international call centers in the National Capital Region (NCR) of Delhi, 77.6 percent of participants had some suspicion of insomnia or suspected insomnia. In addition to sleep quality issues, 44.3 percent of participants were cigarette smokers and 37 percent reported physical ailments.[8] Further, a Circadian Technologies study reported that night shift workers were 20 percent more likely to experience severe accidents.[7] Additionally, research shows that these workers may be at greater risk of cardiovascular disease, gastrointestinal disease, psychological disorders, cancers, diabetes, obesity and adverse reproductive outcomes.[7,9]

However, instances also exist where time zone differences can benefit both U.S. and overseas staff. For example, some organizations and practices outsource their operations overseas part-time so that work is performed by overseas staff during their local day-time hours after which their workday concludes and the work they performed is available to U.S. staff who then begin working their day-time schedule.

Training for Overseas Virtual Assistants in Medical Practice

Medical practices would benefit from the adoption of in-house training programs for virtual assistants that includes general knowledge of health care administration and compliance, as well as processes and procedures specific to the practice. Training on the general knowledge of health care administration is available for little or no cost from professional organizations, such as the AMA's Navigating Practice Series and AMA STEPS Forward® Private Practice playbook. Several resources also exist from the Medical Group Management Association. Before implementing any virtual assistant or employee, the medical practice or health care organization would benefit from a clear strategic plan that outlines and addresses the risks previously mentioned.

AMA POLICY

The AMA has several policies related to the appropriate use of overseas virtual assistants for administrative functions within medical practices.

The AMA will work towards its goal of health equity, defined as optimal health for all, by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity (Policy H-180.944, "Plan for Continued Progress Toward Health Equity").

The AMA will also explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens (Policy D-320.982, "Prior Authorization Reform").
Additionally, the AMA:

a. Supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency.
b. Recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment.

c. Supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night.

d. Encourages work environments that operate in a 24/7 hour fashion to have an employee fatigue risk management plan in place (Policy H-135.932, "Light Pollution: Adverse Health Effects of Nighttime Lighting").

DISCUSSION

Opportunities for Overseas Virtual Assistants in Medical Practice

U.S. companies have struggled with staffing shortages since 2021, known as "The Great Resignation".[10] Health care is no exception, and the industry has arguably struggled more with staffing shortages due to higher levels of burnout post-COVID-19 pandemic, higher levels of administrative burden, diminished reimbursement and a decline in overall annual revenue.[11–14]

The ability to quickly find and hire experienced individuals is crucial for the success of medical practices. When practices are short-staffed, physicians take on the extra workload, decreasing time spent with patients and contributing to burnout. Overseas virtual assistants, when successfully integrated into practice operations, can enable medical practices to expand their talent search beyond U.S. borders to choose among an expansive talent pool to quickly hire an experienced workforce at a much lower cost than those based in the U.S. Additionally, virtual assistants do not require physical space to work in the office, thus lowering the physical infrastructure cost for medical practices.

Risks Associated with Utilizing Overseas Virtual Assistants in Medical Practice

Despite expectations, studies show that outsourcing any health care role contains risks such as the loss of control over work quality, exposure of patient health information and other secure data, the lack of provision of anticipated financial benefits and jeopardization of the organization's culture and reputation.[1]

CONCLUSION

Medical practices struggling to fill vacant positions may turn to virtual assistants within the U.S. or overseas. While virtual assistants can offer cost-saving and efficiency benefits to medical practices, it is imperative that practices have a clear strategic plan before hiring a virtual assistant. This plan should include the security of patient information, in-house training/onboarding for the employee, fair pay and working hours, and management of the virtual employee's work quality and engagement with the rest of the practice. The creation of a strategic plan will allow the medical practice to consider all variables and determine how best to utilize a virtual assistant within their practice. With an informed approach, the use of properly trained overseas virtual assistants is an option for medical practices.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm the following policies:
   a. H-385.951- Remuneration for Physician Services
   b. H-180.944 - Plan for Continued Progress Toward Health Equity
   c. H-135.932 - Light Pollution: Adverse Health Effects of Nighttime Lighting; and

2. That Policy H-200.947 be amended to read as follows: "Our AMA: (1) supports the concept that properly trained ~~overseas~~ virtual assistants, in the U.S. or overseas, are an acceptable way to staff administrative roles in medical practices; and (2) will ~~study and offer formal guidance for physicians on how best to utilize overseas virtual assistants to ensure protection of patients, physicians, practices, and equitable employment in communities served, in a manner consistent with appropriate compliance standards~~ create and publish educational materials for medical practices that offer formal guidance on how best to utilize virtual assistants to ensure protection of patients, physicians, virtual assistants and practices."

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31. THE MORRILL ACT AND ITS IMPACT ON THE DIVERSITY OF THE PHYSICIAN WORKFORCE

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies D-295.963, D-350.976, H-200.951, H-350.960, H-350.977 and H-350.981

INTRODUCTION

At the 2022 Annual Meeting of the House of Delegates, the Medical Student Section authored Resolution 308 that asked the American Medical Association (AMA) to:

> (1) work with the Association of American Medical Colleges, Liaison Committee on Medical Education, Association of American Indian Physicians, and Association of Native American Medical Students to design and promulgate medical school admissions recommendations in line with the federal trust responsibility; and (2) amend Policy H-350.981, "AMA Support of American Indian Health Career Opportunities," by addition to read as follows: (2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals. These efforts should include, but are not limited to, priority consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and robust mentorship programs that support the successful advancement of these trainees. (3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population. (5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect. (6) Our AMA will engage with the Association of Native American Medical Students and Association of American Indian Physicians to design and disseminate American Indian and Alaska Native medical education curricula that prepares trainees to serve AI/AN communities.

This resolution was referred for decision, due to concern about legal implications of the first resolve related to both federal and state laws regarding affirmative action, land grant status, and federal trust responsibilities. To inform this action, a management report was subsequently submitted to the Board of Trustees (BOT) entitled "University Land Grant Status in Medical School Admissions." That report noted the central issue is improving the health status of AI/AN communities and the need to increase the number of AI/AN physicians who are uniquely qualified to provide culturally humble care to these communities. Further, it noted there may be risks associated with implementing original Resolution 308-A-22 due to unknown legal implications and potentially unintended and negative consequences for communities that have been historically excluded from medicine. The management report

identified a need to further understand all components of the Morrill Act that may impact efforts to diversify the physician workforce prior to developing any new policy recommendations. It recommended that in lieu of Resolution 308-A-22, the AMA:

1. Work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Association of American Indian Physicians, and Association of Native American Medical Students to increase representation of American Indian physicians in medicine by promoting effective practices in recruitment, matriculation, retention and graduation of American Indian medical students. (Directive to Take Action)
2. Amend Policy H-350.981, "AMA Support of American Indian Health Career Opportunities," by addition and deletion to read as follows:
   (2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees. (3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population. (5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect. (Modify Current HOD Policy)
3. **Study the historical and economic significance of the Morrill Act as it relates to its impact on diversity of the physician workforce. (Directive to Take Action)**

This BOT report is in response to Recommendation #3 above.

BACKGROUND

To better understand the Morrill Act and its impact, it is important to review the history of land acquisition and public education as well as the federal recognition of tribes.

Public education and land acquisition

Support for public education was realized early in the formation of the republic. According to the Northwest Ordinance of 1787, "Knowledge, being necessary to good government and the happiness of mankind, schools and the means of education shall forever be encouraged."[1] Those who did receive instruction were primarily white children. Financing for early schools varied and often charged tuition. Thus, many children were not included, depending on income, race, ethnicity, gender, geographic location, and other reasons. Some rural areas had no schools. The nation's leaders at the time "believed strongly that preserving democracy would require an educated population that could understand political and social issues and would participate in civic life, vote wisely (only white men could vote), protect their rights and freedoms, and resist tyrants and demagogues."[2] Free public education began to expand in the 1830s, with states taking on the provision of public education. Land acquisition, however, was key to implementing such education widely. The largest occupier and 'owner' of such land at the time were American Indians — the native and original caregivers of what is now the United States.

By 1887, American Indian tribes owned 138 million acres. However, the passage of the General Allotment Act of 1887 (The Dawes Act) greatly impacted such ownership as their land became subject to state and local taxation, of which many could not afford. By 1934, the total had dropped to 48 million acres.[3] The Indian Reorganization Act of 1934 (IRA) tamed this era of allotment and marked a shift toward the promotion of tribal self-government. Subsequent Congressional acts impacting tribes and their land — ownership, use, and development — include the following:

- Indian Mineral Leasing Act: 1938
- Indian Self-Determination and Education Assistance Act: 1975

- Indian Mineral Development Act: 1982
- Indian Tribal Energy Development and Self-Determination Act: 2005
- Indian Tribal Energy Development and Self-Determination Act Amendments: 2017

There are approximately 2.4 billion acres in today's United States.[4] About 56 million acres of that land (2.3%) is currently held in trust by the U.S. for various American Indian tribes and individuals, making up the majority of American Indian land.[2] With trust land, the federal government holds legal title but the beneficial interest remains with the individual or tribe. Trust lands held on behalf of individuals are known as allotments. Fee land, on the other hand, is purchased by tribes whereby the tribe acquires legal title under specific statutory authority.

The Morrill Act and land-grant universities

In 1862, Congress passed the Morrill Act named after Senator Justin Morrill of Vermont. "This act made it possible for states to establish public colleges funded by the development or sale of associated federal land grants. The original intention was to fund colleges of agriculture and mechanical arts.[5] Over 10 million acres provided by these grants were expropriated from tribal lands of Native communities. The new land-grant institutions, which emphasized agriculture and mechanic arts, opened opportunities to thousands of farmers and working people previously excluded from higher education."[6] Much of this land was taken from American Indian tribes for the benefit of white people by way of treaties and agreements (many of which the federal government did not uphold its end) as well as seizure. In other words, "The government took the land for which it paid little or nothing, from tribes with little bargaining power, that were impoverished, and that were sometimes subject to threats to withhold rations and other benefits if they did not comply."[7] These now 'public lands' were surveyed into townships, and sections were reserved for public schools; however, the land itself was often sold off, with proceeds used to fund the school program. "The system invited misuse by opportunists, and substantial portions of the educational land-grants never benefited education."[6] Support for land-grants was a significant factor in providing education to white American children.

By way of the Morrill Act, the government granted each state 30,000 acres of public land, issued to its Congressional representatives and senators to be used in establishing a "land grant" university. Some of the land sales financed existing institutions while others chartered new schools. This allocation grew to over 100 million acres. The Morrill land grants put into place a national system of state colleges and universities. Examples of major universities that were chartered as land-grant schools are Cornell University, Washington State University, Clemson University, and University of Nebraska-Lincoln.

Following the Civil War, a Second Morill Act was passed in 1890 to address the exclusion of Black individuals from these educational opportunities due to their race. "It required states to establish separate land-grant institutions for Black students or demonstrate that admission was not restricted by race. The act granted money instead of land."[6] The 1890 Foundation provides additional information about these 19 historically Black colleges and universities (HBCUs), which include Tuskegee University, Tennessee State University, and Alabama A&M University. In 1994, a third land-grant act was passed — the Equity in Educational Land-Grant Status Act — that bestowed land-grant status to American Indian tribal colleges. As a result, these colleges are referred to as the "1994 land-grants."[8] Today's land grant university (LGU) system is comprised of institutions resulting from the above-mentioned acts passed in 1862 (57 original), 1890 (19 HBCUs), and 1994 (35 Tribal). "LGUs are located in all 50 states as well as the District of Columbia and six U.S. territories. Of note, the "1994 institutions receive fewer federal funds administered by National Institute of Food and Agriculture — in total — than 1862 and 1890 institutions, and they are ineligible for certain grant types available to 1862 and 1890 institutions. Whereas the 1862 and 1890 institutions receive federal capacity funds specific to agricultural research and extension (which brings research to the public through nonformal education activities), 1994 institutions do not. Although 1994 institutions have more limited enrollment and offer fewer postsecondary degrees than 1862 and 1890 institutions, some argue that funding for agricultural research and extension at the 1994 institutions is insufficient and should be increased."[9]

Education of American Indians

The inaccurate perception of American Indians as unintelligent and uncivilized led Congress to pass the Indian Civilization Act in 1819 which paid missionaries to educate Natives and promote the government's notion of civility. Most American Indian children at that time were forcefully relocated and brought to these schools to begin the assimilation into the "Western way of life" under the authority of that Act — thus beginning the troubled history

of American Indian boarding schools that is still felt by current generations. One such school built in 1879, the Carlisle Indian Industrial School, coined the term "Kill the Indian to save the man" summarizing a belief system to erase Native culture through assimilation.[10] These children were forcibly separated from their families and not allowed to practice their spirituality, speak their language, or live according to their culture under threat of punishment. They were even given new names. These practices continued through the 1960s. In 1969, a Senate report of the Committee on Labor and Public Welfare, entitled "Indian Education: A National Tragedy--A National Challenge"," summarized the devastating effects of forced assimilation of Native children and the failures of the education system where students also experienced physical abuse, sexual violence, hunger, forced sterilizations, and exposure to diseases. The trauma associated with this contributes to a well-documented historical trauma that has been correlated to the high number of suicides and health inequities experienced by American Indians in the U.S.[11] This trauma has had a devastating impact on the potential number of students who consider enrollment in higher education due to a distrust of any system associated with the U.S. government. Many who have been directly affected by historical traumas have to overcome barriers like depression or other chronic diseases to participate in a system that still does not align to their way of knowing. There was little consideration for the higher education of American Indians (nor how to include a non-colonial perspective) until 1972 with the formation of the American Indian Higher Education Consortium (AIHEC). Through its network of tribal colleges and universities (TCUs), AIHEC "provides leadership and influences public policy on American Indian higher education issues through advocacy, research, and program initiatives; promotes and strengthens indigenous languages, cultures, communities, and tribal nations; and through its unique position, serves member institutions and emerging TCUs."[12]

American Indian affairs and federal recognition of tribes

In 1775, Congress created a Committee on Indian Affairs under the leadership of Benjamin Franklin. The U.S. Constitution (Article I, Section 8, Clause 3) gave Congress the power "to regulate commerce with foreign nations, and among the several States, and with the Indian tribes." The Bureau of Indian Affairs (BIA) — known over the years as the Indian Office, the Indian Bureau, the Indian Department, and the Indian Service —was established in 1824 to oversee and carry out the government's trade and treaty relations with the tribes. The BIA received statutory authority from Congress in 1832; in 1849, it was transferred to the newly created U.S. Department of the Interior.[13] "Over the years, the BIA has been involved in the implementation of federal laws that have directly affected all Americans. The General Allotment Act of 1887 opened tribal lands west of the Mississippi to non-Indian settlers, the Indian Citizenship Act of 1924 granted American Indians and Alaska Natives U.S. citizenship and limited rights to vote, and the New Deal and the Indian Reorganization Act of 1934 restored self-determination and dictated a model the United States expected tribal governments to use. The World War II period of relocation and the post-War termination era of the 1950s led to the activism of the 1960s and 1970s that saw the takeover of the BIA's headquarters and resulted in the creation of the Indian Self-Determination and Education Assistance Act of 1975. This act as well as the Tribal Self-Governance Act of 1994 have fundamentally changed how the federal government and the tribes conduct business with each other."[13] Although the BIA was once responsible for providing health care services to American Indians and Alaska Natives, that role was legislatively transferred to the U.S. Department of Health, Education, and Welfare (now known as the Department of Health and Human Services) in 1954.[13] It remains there under the auspices of the Indian Health Service (IHS). However, funding for this continues to be a problem. In 2019, IHS spending per capita was only $4,078 while the national average spending per capita was $9,726.[14] At that time, it was also reported that American Indians and Alaska Natives (AI/AN) had a life expectancy 5.5 years less than the U.S. all races population (73.0 years compared to 78.5 years) and "die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases."[15] Groups such as the Tribal Sovereign Leaders on the national Tribal Budget Formulation Workgroup (TBFWG) have provided, and continue to provide, significant insights to inform IHS budget requests.

According to the BIA, "a federally recognized tribe is an AI/AN tribal entity that is recognized as having a government-to-government relationship with the United States, with the responsibilities, powers, limitations, and obligations attached to that designation, and is eligible for funding and services from the BIA. Furthermore, federally recognized tribes are recognized as possessing certain inherent rights of self-government (i.e., tribal sovereignty) and are entitled to receive certain federal benefits, services, and protections because of their special relationship with the United States."[16] Over the years, most of today's federally recognized tribes received federal recognition status by way of treaties, acts of Congress, presidential executive orders or other federal administrative actions, or federal court decisions. In 1978, the Department of the Interior issued procedures for federal

acknowledgment of Indian tribes to more uniformly handle requests — found in Part 83 of Chapter 25 of the Code of Federal Regulations.[17] In 1994, Congress enacted the Federally Recognized Indian Tribe List Act. It formally established three ways to achieve federal recognition: (1) by act of Congress, (2) by the administrative procedures under 25 C.F.R. Part 83, or (3) by decision of a United States court. Congress has the authority to terminate a relationship with a tribe, and only Congress can restore its federal recognition. The act also requires the Secretary of the Interior to annually publish information on federally recognized tribal entities.[18]

As of January 2023, there were 574 federally recognized Tribal entities.[19] There are also many tribes that are not state or federally recognized. There are 324 federally recognized American Indian reservations where 13 percent of the AI/AN population lives. The 2020 Census indicates that 87 percent live outside of tribal statistical areas. It also shows that 9.1 million people identify as AI/AN alone or in combination (2.9 percent of total U.S. population).[20]

DISCUSSION

Economic and educational impacts

The Morill Act, as well as the Homestead Act of 1862, had a significant impact on American expansion. The Homestead Act encouraged western migration by providing settlers with 160 acres of land. Such settlers were required to live on and cultivate the land. After five years, they were entitled to the property upon payment of a small filing fee. While they certainly fostered prosperity and educational opportunities for new American settlers, these came at the expense of the original people — American Indians. The economic significance of these acts cannot be understated. In 2019, sixteen land-grant universities retained over half a million acres of Indigenous lands, generating at least $8.7 million.[21] See Appendix A for a table of remaining Morrill Act lands and revenue by university.

In addition to the economic impact, thousands of American Indian families were affected by the Indian Civilization Act and boarding schools. Given the lingering effects to this day, it stands to reason that many AI/AN students have a negative attitude toward the education system. According to the Bureau of Indian Education (BIE), “Native youth have the lowest high school graduation rate of students across all schools. Nationally, the AI/AN high school graduation rate is 69 percent, far below the national average of 81 percent.”[22] The BIE funds elementary and secondary schools on 64 reservations in 23 states, serving approximately 42,000 Indian students.[23] These BIE schools hold an average graduation rate of 53 percent. The BIE also serves AI/AN post-secondary students through higher education scholarships, supports funding for tribal colleges and universities, and directly operates two post-secondary institutions — Haskell Indian Nations University in Kansas and the Southwestern Indian Polytechnic Institute in New Mexico.

Medical education and the physician workforce

Significant school dropout rates and lower enrollment in higher education have negatively impacted AI/AN representation in medical education and the physician workforce. According to 2022-2023 data from the Association of American Medical Colleges (AAMC), 174 AI/AN students were enrolled in MD-granting medical schools and 38 graduated.[24] This significant decline from enrollment to graduation is very concerning; medical education needs to figure out why and what to do about it. 2022-2023 data from the American Association of Colleges of Osteopathic Medicine (AACOM) indicated 107 AI/AN students were enrolled in DO-granting medical schools and 12 graduated.[35,36] This represents a 27.4 percent increase in AI/AN enrollment for 2022-2023. The entire educational pathway (PreK-12 and undergraduate) may need to be considered to help AI/AN students to prepare for their studies, promote a sense of belonging, and avail themselves of mentorship opportunities. Tribes have a vested interest in the training of AI/AN students, given they are more likely to return to and serve their own communities as physicians. Such efforts will ultimately foster tribal self-governance and self-determination.

Several universities have taken steps to increase AI/AN representation in medical schools. In 1973, the University of North Dakota launched the Indians Into Medicine (INMED) program, which has recruited, supported, and trained 250 AI/AN physicians. This program has served as a model for other health professions within the university as well as for other medical schools that receive IHS funding. Since many students face financial hardship, INMED offers a free summer program called Med Prep that provides students with stipends, and it helps its medical school students identify potential scholarship options. The university went one step further in 2020 to launch the country’s first PhD. program in Indigenous health.[25] In 2020, the Oklahoma State University’s College of Osteopathic Medicine (OSU-

COM) at the Cherokee Nation established the first medical school established on a Native American reservation, which is a significant achievement among medical schools in relation to the AI/AN population. This medical school just graduated its first inaugural class of "nine Native graduates, who make up more than 20 percent of the class of 46 students".[37] Also, fifteen Native American students graduated from OSU-COM's Tulsa campus. "OSU-COM graduates include students from 14 different tribes including the Cherokee, Choctaw, Muscogee, Seminole, Chickasaw, Alaska Native, Caddo and Osage tribes".[37] Another example is Oregon Health & Science University (OHSU) School of Medicine and its Wy'east Pathway, a 10-month postbaccalaureate program for AI/AN students who unsuccessfully applied to medical school, have an MCAT score below a certain cutoff, or lack clinical experience. The program provides biomedical and MCAT classes as well as cultural support and skills-building to promote success in medical school.[26] Not only do programs like these directly support AI/AN students, but they also promote collaboration with and inclusion of non-indigenous allies. This combination can help to turn the tide on the workforce issue.

The impact of low representation in medical schools is evident when examining the diversity of physician workforce. In 2022, 0.3% of active physicians identified as AI/AN.[27] According to a 2018 report from the U.S. Government Accountability Office, the vacancy rate at IHS clinics among staff physician positions was about 29% across the eight IHS geographic regions; the highest vacancy was 46% in the areas servicing Bemidji, Minnesota, and Billings, Montana.[28] In addition to representation in practicing medicine, there are also deficits in AI/AN representation in academic positions. One study found that, compared with their white peers, AI/AN individuals had 48% lower odds of holding a full-time faculty position post residency.[29]

As mentioned in other parts of this report, there is distrust in colonial constructs (U.S. laws, policies, and institutions), but there may also be distrust in the colonial medicine through IHS because of the history of forced sterilization and because traditional forms of medicine were outlawed (as well as any religious/cultural beliefs associated with them). In fact, the Department of the Interior's 1883 Code of Indian Offenses noted that "any medicine man convicted of encouraging others to follow traditional practices was to be confined in the agency prison for not less than 10 days or until he could provide evidence that he had abandoned his beliefs."[30] This context has given rise to a distrust of medicine and medical education that continues today.

In June 2023, the Supreme Court of the U.S. (SCOTUS) issued a ruling on affirmative action that eliminated race as a consideration in college and universities' admission processes. This ruling should not change tribal colleges; however, will it likely impact AI/AN students who attend non-tribal institutions because most wrongly collect tribal identity as a racial category. "Most, if not all, mainstream colleges and universities rely entirely on self-reporting when it comes to determining tribal identity of students. This means if a Native student doesn't indicate they are a tribal citizen, then they are not counted as such."[31] This lack of data can impact the understanding of student enrollment as well as funding opportunities. It is critical to re-emphasize that "Native American" is not only a racial category but also the designation which gives those who are enrolled in federally recognized tribes a protected classification by treaty and is not subject to the SCOTUS decision on race/ethnicity. Many schools may not include identifying Native Americans in their admissions consideration as they may fear violation of the SCOTUS decision.

The AMA's role: accountability and restitution

The AMA and its members play a complicated role in the history of American Indians. AMA members were party to the claiming of land in the "Western territories" in the mid-1850s, as described in the A-1857 report "Report on the Fauna and Medical Topography of Washington Territory. AMA archives contain a 1865 report entitled "On Some Causes Tending to Promote the Extinction of the Aborigines of America" which details study of the Onondoga tribe, concluding "But those of us who pity and strive to arrest the downward course of this remnant of the original lords of the forest, may delay what we are wholly unable to prevent, for I much fear that before the poor Indian has learned the laws of his physical nature and how to obey them, economy of time and means, industry, and reliance upon his own muscles and broad acres for his support, instead of looking for the government to hire his teacher and physician, and for his wants to be met by others, without forecast and plan of us own — before these radical changes in his habits are effected — the waning remnant of the Onondagas will forever have passed away."[32]

Physicians were involved in American Indian boarding schools, the development of the Indian Health Service, and the study of illnesses and healing practices on AI/AN tribes. Their works were published in JAMA and included:

- The Medicine and Surgery of the Winnebago and Dakota Indians (1883)
- Improved Sanitary and Social Conditions of the Seminoles of Florida (1896)
- Indian Method of Treating Measles (1903)
- The Indian Medical Service (1913)

Past harms also include the AMA's role in promulgating discriminatory practices resulting from the Flexner Report, a landmark 1910 criticism of U.S. medical education resulting in a reduction in the number of medical schools including the closing of 5 out of the 7 historically black medical schools. Past decisions such as these continue to negatively impact populations in need. The AMA acknowledges that AI/AN populations experience significant health disparities up to the present including lower access to care and underfunding of public programs such as the Indian Health Service serving AI/AN communities. In addition, AI/AN persons continue to be severely underrepresented in the physician and healthcare workforce.

The AMA launched various supportive efforts such as:

- Asked the federal government to step in to stop the spread of trachoma in Native communities (A-1924) and provide better health services for the population (A-1929);
- Issued AMA Statement on Infant Mortality (A-1968);
- Advocated for the transfer of functions relating to health and hospitalization of American Indians from the Bureau of Indian Affairs to the U.S. Public Health Service (I-1953);
- Appealed for more funding for hospitals and health services on reservations (I-1957);
- Collaborated with the IHS on efforts related to health care delivery and health aide training programs (I-1970);
- Led large-scale study of health care for American Indians that was used to guide the Senate's "Indian Health Care Improvement Act" of 1976 (I-1973);
- Created Project USA to recruit physicians to medically underserved areas, including AI/AN reservations (I-1975);
- Sought to exempt Indian Health Services from competitive procurement practices regulations (A-1984);
- Initiated a project with the AAIP to improve health care for American Indians (A-1995);
- With the National Medical Association, established the Commission to End Health Care Disparities in 2004 – a collaboration of health care organizations to address racial and ethnic health care disparities and diversity in the physician workforce.
- In 2013, the AMA launched its innovative "Accelerating Change in Medical Education" initiative to rebuild medical education from the ground up. Now known as the ChangeMedEd initiative, this effort has fostered collaborations with schools like Oregon Health & Science University School of Medicine and the University of Washington School of Medicine to increase the numbers of AI/AN students and faculty.

Although the Commission was retired in 2016, a new effort emerged in 2018 through the adoption of policy calling for a strategic framework to address health equity on a national scale — resulting in the creation of the AMA Center for Health Equity. Among other things, the Center is leading a task force that will "guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education. …The task force will inform and advise the AMA on ways to establish restorative justice dialogues between AMA leaders, physicians from historically marginalized racial and ethnic groups and their physician associations, and other critical stakeholders."[33]

Recently, an AMA article from December 2023 addressed vacancies at the Indian Health Service. Also, an AMA Update on January 8, 2024 discussed how tribal medical education programs could solve the rural health care crisis. Featuring Oklahoma State University College of Osteopathic Medicine's unique partnership with The Cherokee Nation, the discussion addressed the importance of physicians truly understanding the communities they serve.

AMA Advocacy has been actively participating in efforts to support AI/AN populations and related physicians. Federal efforts in just the last two years include:

- May 2022: Letter sent to Senators Mastro and Murkowski in support of the Indian Health Service Health Professions Tax Fairness Act (S.2874).
- April 2023: Letter sent to U.S. Department of Agriculture addressing Menu Planning Options for American Indian and Alaska Native Students.

- October 2023: Letter sent to U.S. Department of Health and Human Services and Indian Health Service to highlight the importance of high quality, timely care for American Indians, Alaska Natives, and Native Hawaiians, particularly as it related to physician and medical student members.
- February 2024: Multi-organizational letter sent to both the House Appropriations Subcommittee on Interior and Senate Appropriations Subcommittee on Interior, Environment, and Related Agencies, Environment, and Related Agencies. This letter detailed support for the inclusion of $30 million in new funding in the FY2025 Interior, Environment, and Related Agencies appropriations bills to address chronic clinical staff shortages across Indian Country through GME programming.

The AMA Foundation (AMAF) funds the Physicians of Tomorrow Program. This program distributes a $10,000 tuition assistance scholarship to medical students approaching their final year of school with the goal of creating a diverse cohort of students who are dedicated to serving underserved communities. The AMAF is also bringing attention to AI/AN issues in medical education, as seen in a 2022 article featuring AMA members.
The AMA Ed Hub™ offers a variety of equity-related educational opportunities — from its panel discussion on Truth and Reconciliation in Medicine to its Prioritizing Equity series. Titles of relevance include:

- For Us, By Us: Advocating for Change in Native Health Policy
- Getting to Justice in Education
- The Root Cause and Considerations for Health Care Professionals
- How the Past Informs the Present in Healthcare

RELEVANT AMA POLICIES

The AMA has several policies in support of AI/AN tribes and communities as well as students and trainees in order to foster diversity of the physician workforce in an effort to improve public health including AI/AN populations. For example:

- AMA Support of American Indian Health Career Opportunities H-350.981 promotes recruitment of AI/AN into health careers including medicine and the concept of AI/AN self-determination.
- Promising Practices Among Pathway Programs to Increase Diversity in Medicine D-350.980 establishes 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.
- Underrepresented Student Access to US Medical Schools H-350.960 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.
- Strategies for Enhancing Diversity in the Physician Workforce H-200.951 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.
- Cultural Leave for American Indian Trainees H-350.957 recognizes the importance of cultural identity in fostering trainee success and supports accommodating cultural observances.

See Appendix B for the full policies. Additional policies can be accessed in the AMA Policy Finder database, which include:

- Strategies for Enhancing Diversity in the Physician Workforce D-200.985
- Continued Support for Diversity in Medical Education D-295.963
- AMA Support of American Indian Health Career Opportunities H-350.981
- Indian Health Service H-350.977
- Desired Qualifications for Indian Health Service Director H-440.816
- Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987
- Improving Health Care of American Indians H-350.976
- Plan for Continued Progress Toward Health Equity H-180.944

SUMMARY AND RECOMMENDATIONS

This report illuminates these concerns as well as the substantial part that medical education and organized medicine has played and can continue to play for the betterment of the physician workforce and AI/AN students and populations. Organizations like the Association of American Indian Physicians (AAIP) hold an esteemed role in

such efforts. AAIP was established in 1971 by a group of 14 AI/AN physicians to support AI/AN communities and serve as an educational, scientific, and charitable nonprofit.

As stated in the AAMC's 2018 publication, Reshaping the Journey: American Indians and Alaska Natives in Medicine, "Medical schools are chiefly responsible for the development of what the physician workforce looks like today and what it will look like in the future…. We must view this issue as a national crisis facing not just the American Indian-Alaskan Native (AI/AN) communities, but all medical schools and teaching hospitals…. We need transformative thinking and a new systems-based approach if we are to resolve this crisis with a plausible solution."[34] Diversification of the physician workforce is imperative to meeting the health care needs in underserved communities across the U.S., particularly AI/AN populations. Also, medical education has much to learn from tribal nations, schools, and organizations to provide more culturally responsive information, understanding, and support.

The Board of Trustees therefore recommends that the following recommendations be adopted, and the remainder of this report be filed. That our AMA:

1. Amend AMA Support of American Indian Health Career Opportunities H-350.981 by addition to read:
   (4) Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations to include training a workforce from and for these tribal nations.
   (6) Our AMA acknowledges the significance of the Morrill Act of 1862, the resulting land-grant university system, and the federal trust responsibility related to tribal nations.

2. Amend AMA Support of American Indian Health Career Opportunities D-350.976 by deletion of clause (2) as having been accomplished by this report.
   ~~(2) study the historical and economic significance of the Morrill Act as it relates to its impact on diversity of the physician workforce~~.

3. Amend AMA Support of American Indian Health Career Opportunities D-350.976 by addition of a new clause to read:
   Convene key parties, including but not limited to the Association of American Indian Physicians (AAIP) and American Indian/Alaska Native (AI/AN) tribes/entities such as Indian Health Service and National Indian Health Board, to discuss the representation of AI/AN physicians in medicine and promotion of effective practices in recruitment, matriculation, retention, and graduation of medical students.

4. Reaffirm the following policies:
   a. Indian Health Service H-350.977
   b. Underrepresented Student Access to US Medical Schools H-350.960
   c. Strategies for Enhancing Diversity in the Physician Workforce H-200.951
   d. Continued Support for Diversity in Medical Education D-295.963
   e. AMA Support of American Indian Health Career Opportunities D-350.976.

APPENDIX A: Remaining Morrill Act lands and revenue by university

University	Total Morrill acres found	Endowment raised as of 1914	Remaining acres with surface rights	Surface royalties raised, FY 2019	Remaining acres with mineral rights	Mineral royalties raised, FY 2019
Colorado State University	89,321	$185,956	19,130	$77,526	42,572	$662,596
Kansas State University	87,290	$491,746	0	N/A	6,080	$163,345

Montana State University	140,385	$533,149	63,474	$623,941	77,929	$6,670
New Mexico State University	248,964	$241,909	194,571	$1,217,672	254,200	$353,587
North Dakota State University	130,471	$455,924	15,117	$308,142	66,109	$2,874,800
South Dakota State University	159,832	$128,804	36,617	$608,583	160,000	$27,365
University of Arizona	143,684	$450,000	UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN
University of California	150,525	$732,233	0	N/A	441.6	$1,947
University of Idaho	87,445	$129,615	33,527	$358,258	70,000	$1,188
University of Minnesota	94,631	$579,430	0	N/A	240	$0
University of Missouri	270,613	$363,441	14,787	UNKNOWN	0	N/A
University of Nebraska	89,920	$560,072	6,173	$426,619	0	N/A
University of Wisconsin	235,690	$303,594	0	N/A	6,400	$0
University of Wyoming	89,849	$73,355	71,066	UNKNOWN	UNKNOWN	UNKNOWN
Utah State University	198,837	$194,136	27,577	$83,769	51,724	$943,843
Washington State University	90,081	$247,608	71,147	$4,250,000	86,657	$1,936

The land-grant universities still profiting off Indigenous homelands, High Country News, 2020.

APPENDIX B – RELEVANT AMA POLICIES

AMA Support of American Indian Health Career Opportunities H-350.981

AMA policy on American Indian health career opportunities is as follows:
(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded. (2) Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees. (3) Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population. (4) Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of

American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. (5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.

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.

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; (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; (6) will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine; (7) will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school; (8) will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants; (9) will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine; and (10) will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, (1) (a) encouraging state and local governments to make quality elementary and secondary education available to all.

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.

Cultural Leave for American Indian Trainees H-350.957
Our AMA recognizes the importance of cultural identity in fostering trainee success and encourages residency programs, fellowship programs, and medical schools to accommodate cultural observances for trainees from American Indian, Alaska Native, and Native Hawaiian communities.

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 their 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 and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities. 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 unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order 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.

Continued Support for Diversity in Medical Education D-295.963
Our AMA will: (1) publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (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; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement; (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty; (8) recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts; and (9) collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure.

AMA Support of American Indian Health Career Opportunities H-350.981
AMA policy on American Indian health career opportunities is as follows:
(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded. (2)) Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time

to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees. (3) Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population. (4) Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. (5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.

Indian Health Service H-350.977
The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population. (2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation. (3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps. (4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued. (5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population. (6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs. (7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.

Desired Qualifications for Indian Health Service Director H-440.816
Our AMA supports the following qualifications for the Director of the Indian Health Service:
1. Health profession, preferably an MD or DO, degree and at least five years of clinical experience at an Indian Health Service medical site or facility. 2. Demonstrated long-term interest, commitment, and activity within the field of Indian Health. 3. Lived on tribal lands or rural American Indian or Alaska Native community or has interacted closely with an urban Indian community. 4. Leadership position in American Indian/Alaska Native health care or a leadership position in an academic setting with activity in American Indian/ Alaska Native health care. 5. Experience in the Indian Health Service or has worked extensively with Indian Health Service, Tribal, or Urban

Indian health programs. 6. Knowledge and understanding of social and cultural issues affecting the health of American Indian and Alaska Native people. 7. Knowledge of health disparities among Native Americans / Alaska Natives, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities. 8. Experience working with Indian Tribes and Nations and an understanding of the Trust Responsibility of the Federal Government for American Indian and Alaska Natives as well as an understanding of the sovereignty of American Indian and Alaska Native Nations. 9. Experience with management, budget, and federal programs.

Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987
1. Our AMA will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers. 2. Our AMA will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service. 3. Our AMA adopts as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction. 4. In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service. 5. Our AMA will request that Congress: (A) amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; (B) include our recommendation for the Indian Health Service (HIS) Advanced Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations. 6. Our AMA supports an increase to the Federal Medical Assistance Percentage (FMAP) to 100% for medical services which are received at or through an Urban Indian Organization that has a grant or contract with the Indian Health Service (IHS) and encourages state and federal governments to reinvest Medicaid savings from 100% FMAP into tribally driven health improvement programs.

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens. (2) The federal government provide sufficient funds to support needed health services for American Indians. (3) State and local governments give special attention to the health and health-related needs of non-reservation American Indians in an effort to improve their quality of life. (4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs. (5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians. (6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents. (7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems. (8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians. (9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside. (10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians. (11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

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32. INDEPENDENT MEDICAL EVALUATION

Informational report; no reference committee hearing.

HOD ACTION: FILED

At the 2023 Annual Meeting, the House of Delegates referred Resolution 007, "Independent Medical Evaluation," to the Board of Trustees. Resolution 007 specifically asked:

> That our American Medical Association study and report back at the 2024 Annual Meeting on the Independent Medical Evaluation (IME) process and recommend standards and safeguards to protect injured and disabled patients. (Directive to Take Action)

The resolution was referred to the Board of Trustees for decision in September 2023. At that meeting, the Board of Trustees reviewed the Management report and decided to complete the study, as outlined in the report.

The following study, presented as an informational report, examines IME standards, processes and procedures that impact the rights of examinees and physicians throughout the IME process, as set forth in the resolution. Topics discussed include professional qualifications, ethics, objectivity, safety, and access.

Despite their widespread use, IME processes and approaches can significantly vary across different jurisdictions, which may impact the rights and responsibilities of examinees and physicians. Examining specific jurisdictional regulation protocols such as codes of ethics, educational requirements and licensure protocols are beyond the purview of this report.

PURPOSE AND DEFINITION OF INDEPENDENT MEDICAL EVALUATIONS (IME)

In general, an IME is "a usually one-time evaluation performed by an independent medical examiner who is not treating the patient or claimant, to answer questions posed by the party requesting the IME".[1] The most common purpose of an IME is to provide a timely, impartial, and objective assessment of an examinee's medical condition to determine appropriate diagnoses, causality, the extent of injuries or disabilities, and need for accommodation. This is often required in the context of legal or insurance matters. Unless a limited scope IME is stipulated by the requesting party or refused by the examinee, an IME includes the essential element of a medical assessment, specific to the defined scope of the requested evaluation, including history, examination, and review of relevant records and diagnostic studies.[3]

The goal of the IME physician is to provide an unbiased, evidence-based assessment regarding the individual's medical status, including the nature and extent of injuries or disabilities. During an IME, the examinee's relevant medical history, current condition, test results, functional status, and any relevant medical records are assessed. The *AMA Guides to the Evaluation of Permanent Impairment* (AMA Guides) provide a reliable measurement framework for assessing permanent impairment and are required in many jurisdictions.[1,2] An impairment rating may be a component of the IME, which is defined as a "consensus-derived percentage estimate of loss of activity, which reflects severity of impairment for a given health condition, and the degree of associated limitations in term of Activities of Daily Living (ADLs)".[1] The AMA Guides Editorial Panel ensures the AMA Guides are up to date with the latest evidence-based medicine and science.

While IMEs and corresponding processes vary among different contexts and jurisdictions, one commonality is that there is no patient-physician relationship, and many jurisdictions avoid using the term "patient" in the context of IMEs because this can be construed to establish a patient-physician relationship. Instead, the term "examinee" is used.[1,3,4]

Common Scenarios for IMEs

The applications and requirements of an IME can differ significantly based on different scenarios. For example, in workers' compensation, IMEs commonly evaluate the nature and extent of occupational-related injuries, care-related issues and authorizations, physical work capabilities, and causality. For insurance claims, particularly those involving personal injury, bodily injury, and automobile accidents, IMEs can verify the legitimacy and extent of the alleged injuries and medical status. In many jurisdictions, an injured party's failure to comply with insurer requests for an IME or a claim investigation to support a claims determination may be grounds for a denial of the claim and benefits. Additionally, IMEs are utilized in legal disputes or tort litigation involving alleged bodily, physical, mental, or other injury claims. Petitioner filings, court or other findings may result in an IME order to obtain an objective assessment of injuries, disabilities, and/or other issues.

PROFESSIONAL QUALIFICATIONS FOR INDEPENDENT MEDICAL EVALUATORS

The selection of the medical professional with the appropriate qualifications is a fundamental aspect that can determine the examination's thoroughness and impact the outcome of claims, benefits, and legal disputes. Judges or juries critically assess the qualifications and expertise of the physician to ensure that their evaluation is reliable and based on sound medical judgment. The presence of established standards and resources for IME training and certification underscores the importance of having skilled, ethical, and unbiased medical professionals conduct these examinations within their scope of practice.

Jurisdictional regulations or protocols may include specific criteria for physician qualifications. The following qualifications are commonly recommended across most jurisdictions:

- Unrestricted license to practice medicine in the jurisdiction.
- Relevant board-certification in a specialty recognized by the American Board of Medical Specialties.

- Competency in report-writing and the ability to provide deposition and expert testimony are essential. These skills ensure that the physician can effectively communicate their medical findings and rationale in legal or insurance contexts.
- Professional history should be free from adverse events that could compromise their credibility or impartiality in performing an IME.

Specialized credentials or certification may be required on a jurisdictional-specific basis.

Objectivity and Bias

The IME process should be objective, independent and unbiased with the substantiation of findings and recommendations based upon available information and evidence.[3,4] Physician transparency in reporting and testimony can reinforce impartiality. Having IMEs performed in a timely manner in an appropriately situated and appointed environment is in the best interest of the examinee and involved parties. However, there may be conflicts of interest to consider.

The *AMA Code of Ethics*[5,6] addresses the ethical considerations for physicians employed by businesses or insurance companies, as well as independent medical examiners assessing health or disability. The IME physician may obtain personal information about patients outside an ongoing patient-physician relationship, such as assessments for employers or insurers. It is also important to obtain written consent, as required by law, to provide disclosure to third parties.[6]

While practicing in these roles, physicians have dual responsibilities to both the patient and the employer or third party. However, there is also the additional duty to uphold the obligations of a medical professional. Therefore, the following should be considered:[5]

- Disclose the nature of the relationship with the employer or third party before gathering health information from the patient.
- Explain that the goal is to assess the patient's health or disability independently and objectively, distinguishing it from the traditional fiduciary role of a physician.
- Protect patients' personal health information according to professional confidentiality standards.
- Inform the patient about significant findings during the examination, suggesting follow-up care from a qualified physician when appropriate.

PROTECTIONS FOR THE EXAMINEE

Informed Consent

It is important for examinees to understand their jurisdictionally specific rights and the potential implications of the examination's findings on their claims or legal cases. This information should be communicated to the examinee via the informed consent process. The examiner must explain that there is no physician-patient relationship involved and the evaluation is not a traditional medical evaluation conducted by their treating physician.[3,4] Additionally, the examinee must advise the examiner immediately if any problems are encountered during the evaluation and a report will be provided to the requesting client.

Additional best practices for the informed consent process are as follows:[4]

- Discuss the importance of the examinee’s reading and signing of a written informed consent with the examinee prior to the evaluation.
- Establish the ground rules for the performance of the service.
- Provide the opportunity for the examinee to understand the rationale for the IME, who is requesting the evaluation, and where the report will be sent.
- Ensure the examinee understands what the IME provider can and cannot do.
- Acknowledge that the examinee understands that there will be no physician-patient relationship established.
- Confirm that there will not be a discussion regarding diagnoses nor any recommendations for treatment.
- Indicate that the examinee is consenting to having their history taken and that an examination will occur.
- Clearly state that the IME physician is independent and that any opinions developed are given irrespective of anyone else involved in the claim (a third-party evaluation).

- State that there is an understanding that the results of the evaluation (the report) will only be given to the requesting party (unless there is a jurisdictional rule that requires something else).
- Spend an appropriate amount of time on the informed consent process to ensure that the IME physician can answer questions or clarify points that are not well understood.

IME Report Access

An examinee may have the right to access their IME report, but the process and ease of access can vary based on jurisdiction, the specific policies of the requesting entity (such as an insurance company or employer), and the purpose of the IME. There might be a specific timeframe within which the IME report must be requested or provided.

Examinees should be encouraged to inquire about the request process or seek assistance from their legal representative to understand their rights and the best approach to obtain the IME report. These rights are often outlined in health information privacy laws or regulations concerning workers' compensation and personal injury cases. For IMEs conducted as part of an insurance claim or workers' compensation case, the report is typically part of the claim file. In the context of legal disputes, IME reports may become part of the discovery process, allowing the examinee or their attorney to access the report as part of the case proceedings.

Third-Party Observation

Some jurisdictions may have specific regulations or guidelines that address whether third-party observers are allowed during IMEs. Examinees and their representatives should clarify the rules and policies regarding third-party observers in advance. This might involve consulting with legal counsel, reviewing the request for the IME, and directly communicating with the requesting organization, insurance company, or physician coordinating the examination.

The presence of a third-party observer raises issues of patient privacy, confidentiality, and integrity of the examination process, and research shows that it will bias the evaluation to the extent that in most cases, the results are invalid.[4,7] If a third party is allowed because of jurisdictional rule, the individual undergoing the IME and the third party should agree to confidentiality terms. Any observer will need to agree to not interfere with the examination.

PROTECTIONS FOR PHYSICIANS

The IME physician may be asked to render an opinion based upon incomplete information, inadequate records, a limited in person evaluation, or an examinee who is uncooperative or misrepresenting their true status for potential secondary gain. The examiner may be requested to report on the nature and extent of alleged, documented or observed injuries, and function based upon the available information and findings, within a reasonable degree of certainty.

Despite challenges that may arise during an IME, the evaluating physician’s goal remains to provide an unbiased, objective opinion regarding the examinee's medical and/or physical status. When possible, physicians should identify and request additional records and information if needed to objectively provide their report. Indicating that conclusive findings cannot be rendered with the available information may be necessary in some circumstances.

In addition to examinee rights, the following list outlines best practices for minimizing professional risks for physicians conducting IMEs:

- Detailed record-keeping of the IME process, findings, and the basis for conclusions to safeguard against potential disputes or allegations of misconduct. Documentation should be clear, factual, and free of any speculation.
- Safeguarding all IME-related documents and records, including during transport.
- Clear, professional communication with all parties involved. This includes the ability to explain medical terms and findings in layman's terms, which can reduce misunderstandings and conflicts.
- Only performing IMEs in their respective area of specialty and board certification. If an examination or interpretation of findings falls outside expertise, consult with other specialists.

- Having appropriate professional liability insurance that covers IMEs to provide financial and legal protection in case legal claims arise.
- Staying informed about the latest developments and any changes in laws or guidelines related to IMEs to avoid practices may cause exposure to liability.
- Seeking advice, when in doubt, on complex issues related to IMEs from legal professionals or a professional association.
- Identifying, disclosing and avoiding conflicts of interest, such as evaluating family members.
- Taking precautions disclosing information to third parties, limiting it to the minimum necessary for the intended purpose and remove individually identifying information before releasing aggregate data or statistical health information.[6]

STRUCTURAL BARRIERS IMPACTNG PHYSICIANS AND EXAMINEES

There is a national shortage of qualified physicians to meet the market demands for IMEs and associated timely report submissions. The shortage impacts timely decision making and authorization of care and subsequent appeals, creating an extra burden on examinees. The shift towards health care delivery consolidation and away from independent practice further contributes to the difficulty of scheduling and administering IMEs. Interstate and compact licensing affording physicians the right to perform IMEs beyond the boundaries of their jurisdiction could increase the pool of available qualified physicians to perform IMEs and promote access to care.

CONCLUSION

It is important for physicians to implement standards and safeguards when performing IMEs to protect examinees, themselves, and all other involved parties. Regulations, professional requirements, and protocols for IMEs differ both by jurisdiction and context in which the IME is being sought. However, despite myriad differences across jurisdictions, this report outlines numerous best practices for conducting IMEs that can enhance the quality of the examinee experience, as well as the scientific and evaluative rigor of the evaluating physician within this vital process. Additionally, critical elements like a thorough informed consent process, clear communication with the patient, and practicing within one's clinical expertise are some of the methods that can be deployed to protect both the IME physician and the examinee.

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33. EMPLOYED PHYSICIANS

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

BACKGROUND

At its November 2021 Special Meeting, the House of Delegates (HOD) referred Resolution 615, which asked AMA to take a variety of actions to ensure that the voice of employed physicians is heard within the organization.

BOT Report 9-I-22 subsequently argued that creation of an employed physician caucus, already in the works at that time via efforts of the Organized Medical Staff Section (OMSS), would be the most appropriate mechanism for giving voice to employed physicians in the HOD. The report concluded that while it is beyond the scope of the Board to establish caucuses, the Board fully supported the creation of an employed physician caucus in lieu of the asks of original Resolution 615.

As directed by BOT Report 9, this follow-up report provides an update on the caucus and representation of employed physicians within our AMA.

DISCUSSION

The inaugural meeting of the OMSS-convened employed physician caucus was held at the 2022 Interim Meeting. Since then, the caucus has met in conjunction with each Annual and Interim meeting, and between meetings as the need has arisen. Attendance at these meetings has ranged from 15 to 20 participants per meeting, engaging not only OMSS members but also members from most of the other AMA sections as well as members of the HOD who are not actively involved in any section.

Facilitated by OMSS leadership, caucus meetings have focused on (1) discussion of resolutions and reports under consideration by the HOD that are especially relevant to employed physicians, and (2) general discussion of issues facing employed physicians and how AMA might address them, whether through the policymaking process or otherwise. Through these actions, the group has directly lent its expertise to the HOD, with one key example being the contributions of the caucus to the development of OMSS-sponsored Resolution 017-A-23, which established AMA's definition of "employed physician." Additionally, the group has served as a resource for AMA staff addressing employment matters – for example, providing input on recent revisions to the *AMA Physicians' Guide to Hospital Employment Contracts* and allowing for observation of the caucus by AMA staff to garner ideas for a series of news articles on physician employment.

In 2024, the OMSS-convened employed physician caucus will focus on formalizing its structure and processes, developing a charter that outlines caucus membership requirements, how caucus leadership is selected, and the process by which the caucus determines positions it will voice on items of business under consideration in the HOD. The caucus will next meet on Saturday, June 8, from 9:30 to 10:30 a.m. at the Hyatt Regency Chicago (see Speakers' Letter for room location), and all AMA members are invited to attend. The Board of Trustees looks forward to the continued evolution of the caucus and its success in representing the interests of employed physicians within our AMA.

RECOMMENDATION

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

1. That AMA policy D-405.969 be rescinded as having been accomplished by this report.

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

Informational report; no reference committee hearing.

HOD ACTION: FILED

INTRODUCTION

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

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

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

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

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

DATA SOURCES

Lists of delegates and alternate delegates are maintained in the Office of House of Delegates Affairs and are based on official rosters provided by the relevant society. The lists used in this report reflect 2023 year-end delegation rosters.

Data on individual demographic characteristics are taken from the AMA Physician Professional Data, which provides comprehensive demographic, medical education, and other information on all United States and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA membership and the total physician and medical student population are taken from the Masterfile and are based on 2023 year-end information.

Some key considerations must be kept in mind regarding the information captured in this report. Vacancies in delegation rosters mean that the total number of delegates is less than the 705 allotted at the November 2023 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. As such, the total number of delegates and alternate delegates is 1091 rather than the 1410 allotted. Race and ethnicity information, which is provided directly by physicians, is missing for approximately 15 percent of AMA members and approximately 19 percent of the total United States physician and medical student population, limiting the ability to draw firm conclusions. Efforts to improve AMA data on race and ethnicity are part of Policy D-630.972. Improvements have been made in collecting data on race and ethnicity, resulting in a decline in reporting race/ethnicity as unknown in the HOD and the overall AMA membership.

CHARACTERISTICS OF AMA MEMBERSHIP AND DELEGATES

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

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

Table 1. Basic Demographic Characteristics of AMA Members & Delegates, December 2023

2023	AMA Members	All Physicians and Medical Students	AMA Delegates & Alternate Delegates 1,2
Total	282,952	1,514,092	1,091
Mean Age (Years)	46.7	52.8	54.2
Age			
Under Age 40	52.9%	30.5%	19.1%
40-49 Years	11.1%	17.2%	18.1%
50-59 Years	9.5%	15.8%	20.2%
60-69 Years	9.0%	15.6%	25.8%
70 or More	17.5%	20.8%	16.9%
Gender			
Male	58.9%	61.9%	60.8%
Female	40.5%	37.2%	39.0%
Unknown	0.6%	0.9%	0.2%
Race/Ethnicity			
American Indian or Alaskan Native	0.17%	0.17%	0.2%
Asian	17.5%	16.7%	14.8%
Black or African American	5.3%	4.5%	5.8%
Hispanic	4.1%	4.5%	3.3%
Mixed Race/Ethnicity	5.8%	4.0%	3.1%
Native Hawaiian or Other Pacific Islander	0.05%	0.04%	0.0%
White	50.4%	49.9%	62.9%
Unknown	14.9%	18.5%	8.3%
Other	1.8%	1.7%	1.6%
Education			
US or Canada	81.3%	77.2%	90.6%
IMG	18.7%	22.8%	9.4%

[1] There were 319 vacancies as of year's end.

[2] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.

[3] Age as of December 31. Mean age is the arithmetic average.

[4] Includes other self-reported racial and ethnic groups.

Table 2. Life Stage, Present Employment and Self-Designated Specialty[5], December 2021

2023	AMA Members	All Physicians and Medical Students	AMA Delegates & Alternate Delegates 1,2
Life Stage			
Student	18.2%	7.7%	6.1%
Resident	29.0%	11.5%	6.9%
Young (under 40 or first 8 years in practice)	10.0%	15.3%	6.5%
Established (40-64)	20.8%	36.7%	49.9%
Senior (65+)	22.0%	28.7%	30.6%
Present Employment			
Self-Employed Solo Practice	5.8%	7.2%	10.5%
Two physician practice	1.3%	1.7%	1.6%
Group practice	23.5%	38.9%	38.5%
HMO	0.2%	0.1%	0.8%
Medical School	0.8%	1.3%	3.4%
Non-government hospital	3.0%	4.2%	8.2%
State or local government hospital	3.4%	5.6%	10.4%
US government	0.8%	1.5%	2.5%
Locum Tenes	0.1%	0.2%	0.3%
Retired/Inactive	11.0%	12.8%	7.3%
Resident/Intern/Fellow	29.1%	11.6%	6.9%
Student	18.3%	7.8%	6.1%
Other/Unknown	2.8%	7.1%	3.6%
Specialty			
Family Medicine	7.9%	10.3%	10.8%
Internal Medicine	21.0%	22.8%	20.3%
Surgery	12.8%	12.8%	20.0%
Pediatrics	5.5%	8.6%	4.0%
Obstetrics & Gynecology	4.9%	4.4%	6.8%
Radiology	3.4%	4.3%	4.9%
Psychiatry	4.4%	5.1%	4.5%
Anesthesiology	3.5%	4.4%	3.4%
Pathology	1.7%	2.2%	2.1%
Other Specialty	16.6%	17.4%	17.0%
Students	18.2%	7.7%	6.1%

[5] See Appendix for a listing of specialty classifications.

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

Appendix - Specialty classification using physician's self-designated specialties

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology

Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

35. MITIGATING THE COST OF MEDICAL STUDENT PARTICIPATION IN AMA MEETINGS

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy G-665.998

At the 2022 Annual Meeting, the House of Delegates (HOD) adopted Resolution 617, directing AMA to "study mechanisms to mitigate costs incurred by medical students, residents and fellows who participate at national in-person AMA conferences." This report describes the costs of and funding opportunities for student travel to AMA meetings and explores current and future AMA efforts to mitigate meetings costs for medical students.

BACKGROUND

Involvement opportunities at in-person meetings

Annual and Interim Section Meetings are the primary in-person AMA involvement opportunity for medical students. The Medical Student Section (MSS), whose meeting participants are a mixture of students formally representing their medical schools in policymaking and other business activities (~30 percent) and students attending to participate in non-business activities such as education sessions and networking (~70 percent), typically meets over the two days immediately before the opening of the HOD. Over the last several years, policymaking activities have accounted for a range of approximately 60 to 75 percent of MSS meeting time, with education sessions and other activities accounting for the balance, 25 to 40 percent, of meeting time. While all medical students are invited to attend the MSS meeting, the nature of the MSS representational structure sets the expectation that at least one representative from each medical school/campus attend the meeting. In-person attendance at MSS meetings has ranged from 350 to 400 since the post-pandemic return to in-person meetings at A-22.

In addition to participation in Section meetings, many students attend the HOD meeting as medical student regional delegates/alternates (52 in 2023, about 15 percent of all MSS meeting attendees). Travel funding for regional delegates and other student members of the HOD varies from no coverage to full funding, but typically is covered largely by the state medical societies endorsing these members and with whom they are seated in the HOD.

Costs and funding for meeting participation

To better understand the impact of meeting costs and the availability of funding on meeting participation, a survey was distributed to medical students and residents/fellows at the 2022 Interim Meeting and via other MSS and RFS communication channels. 265 completed surveys were received (75 percent medical students, 25 percent residents and fellows), with the following results noted:

- Among those who had never attended an AMA Annual or Interim Meeting (approximately one third of respondents), 80 percent cited lack of funding as a reason for not attending, and, unsurprisingly, nearly all indicated that they would be likely to attend if they did receive funding.

- Among those who had attended an AMA Annual or Interim Meeting (approximately two thirds of respondents), 70 percent received funding – primarily from a state or specialty medical society (50 percent) and/or a medical school/chapter (40 percent). While the level of funding varied, in most cases it covered a majority of meeting-related expenses, and only 10 percent of respondents estimated that they had spent more than $1,000 to attend an AMA Annual or Interim meeting. 66 percent of these respondents said they would not attend AMA meetings if they did not receive funding.

To further assess the cost of meeting participation for medical students, a second survey was distributed to medical students who had registered to attend the 2023 MSS Annual Meeting and/or the 2023 MSS Interim Meeting. 408

individuals responded to the survey, of whom 263 were medical students who had attended at least one MSS meeting in 2023. Responses from 61 students who did not provide cost/funding information were excluded from analysis.

As a starting point, the analysis sought to ascertain cost and funding information for "rank-and-file" student members who do not serve in roles that traditionally are funded by the AMA or another third party. Accordingly, the primary analysis (Table 2) further excluded 72 students with 127 trips who were medical student regional delegates/alternates (whose trip costs typically are covered by the state medical societies that endorse them and with whom they are seated in the HOD[2]) or were MSS Governing Council members or student members of AMA Councils (whose trip costs are covered by AMA).

Table 1: Summary of survey responses

	Individual responses	Trips with cost/funding info
Total survey responses	408	
Excluded: Did not attend a meeting	-145	0
Attended at least one meeting	263	306
Excluded: Did not provide cost/funding info	-61	0
Excluded: GC/Council/HOD members	-72	-127
Final analyzable sample for primary funding analysis	130	179

Table 2 details what these 179 trips taken by non-GC/Council/HOD members (84 at A-23, 95 at I-23) cost and how they were funded. The average cost across all trips was $971. 80 percent of trips were funded at least in part by one or more third parties, receiving an average of $874 third-party funding per trip; the average self-funding for trips that received full or partial third-party support was $204 per trip. By comparison, for the 20 percent of trips that were fully self-funded by the student (i.e., $0 third-party funding received), the average out-of-pocket cost was substantially more, at $547 per trip.

Table 2: Trip cost by manner of funding for non-GC/Council/HOD members

Manner of funding	Portion of 179 trips funded in this manner	Average self-funding	Average third-party funding	Average total trip cost
Fully self-funded (n=36)	20%	$547	$0	$547
Partially funded by third party (n=88)	49%	$332	$631	$963
Fully funded by third party (n=55)	31%	$0	$1,262	$1,262
Partially or fully funded by third party (n=143)	*80%*	*$204*	*$874*	*$1,078*
All trips (n=179)	**100%**	**$273**	**$698**	**$971**

Secondarily, travel costs were analyzed for 127 trips taken by student GC/Council/HOD members, who were excluded from the primary analysis shown in Table 2. As detailed in Table 3, the survey found that 84 percent of trips taken by these student leaders were partially or fully funded by one or more third parties, receiving an average of $1,118 third-party funding per trip; the average self-funding for trips that received full or partial third-party support was $284 per trip. It should be noted that student GC/Council/HOD member roles typically require them to spend more nights at AMA/MSS meetings (up to seven nights for student members of the HOD who also attend the full MSS meeting) than students who attend only the MSS meeting (up to three nights). Consequently, direct comparison of trip costs and funding amounts between GC/Council/HOD members (Table 3) and non-GC/Council/HOD members (Table 2) should be avoided.

[2] See BOT Report 27-A-24 for further discussion of AMA funding of delegates/alternates representing state and specialty medical societies in the HOD.

Table 3: Trip cost by manner of funding for GC/Council/HOD members

Manner of funding	Portion of 127 trips funded in this manner	Average self-funding	Average third-party funding	Average total trip cost
Fully self-funded (n=20)	16%	$923	$0	$923
Partially funded by third party (n=65)	51%	$468	$1,109	$1,577
Fully funded by third party (n=42)	33%	$0	$1,664	$1,664
Partially or fully funded by third party (n=107)	*84%*	*$284*	*$1,327*	*$1,611*
All trips (n=127)	**100%**	**$385**	**$1,118**	**$1,503**

The 145 respondents who did not attend an MSS meeting in 2023 cited the following reasons for not attending. Note, the number and percentages exceed 145 and 100 percent, respectively, because respondents could select multiple reasons for not attending.

Table 4: Reasons for not attending

Reason for not attending	Portion of reason cited
Cost	77% (n=111)
Could not get time off to travel to meeting	33% (n=48)
Did not have defined role at meeting	15% (n=21)
Other students from school were attending	13% (n=19)
Did not want to travel to the meeting	5% (n=7)
Not yet an AMA member or new to MSS	4% (n=6)

Taken together, these survey results indicate that medical students rely largely on third-party funding to attend MSS meetings. Third-party funding currently is available for a significant number of students. Where such third-party funding is available, out-of-pocket student spending is modest. But for those who cannot access third-party funding, travel costs may be a barrier to meeting attendance.

AMA funding of student meeting participation

AMA directly funds medical student travel to Annual/Interim meetings as follows:

- Since 2022, per a directive of the HOD, AMA has funded travel to Annual/Interim meetings for a select group of medical students who attend schools with historically low attendance at MSS meetings and who identify with groups that are underrepresented or disadvantaged in medicine. In 2024, AMA will award 28 such travel grants of up to $500 each.
- Beginning with the 2022-2023 academic year, the AMA Section Involvement Grant (SIG) program has provided each local MSS section (i.e., medical school chapter) with up to two travel grants of up to $250 each per academic year. Additionally, local MSS sections may use their AMA membership commission dollars (i.e., a portion of AMA membership revenue shared with them in exchange for recruiting new members) to fund member travel to Annual/Interim meetings.
- AMA/Section leaders are funded to attend Annual/Interim meetings, which amounts to a total of 18 trips per year for MSS GC members and 14 trips per year for student members of the AMA Councils.

In addition to direct travel funding, AMA provides a variety of resources to mitigate the out-of-pocket cost for members attending meetings—for example:

- AMA negotiates a discounted room block for medical student attendees at each Annual/Interim Meeting, as well as airline and rental car discounts available to all members. For the 2024 Annual Meeting, this hotel discount amounts to approximately $100 per night.
- AMA provides lunch for all MSS Annual/Interim Meeting attendees.

- AMA offers a template letter that medical students can use to seek financial support from their medical schools and state medical societies.

These direct and indirect sources of assistance are detailed and organized on a meeting funding webpage published in advance of each meeting and linked to from the main MSS meeting page.

Student efforts to mitigate travel costs

Medical students who attend AMA meetings engage in a variety of activities to reduce travel costs for themselves and their peers. Perhaps most commonly, students share hotel rooms, which, given that lodging accounts for a substantial portion of overall trip cost, can make the difference between a student being financially unable or able to attend the meeting. Students further mitigate meeting attendance costs through transportation sharing, whether that be carpooling to the meeting, sharing taxis to and from the airport, and so forth. This cost sharing often takes the form of funded students covering some costs for their unfunded peers – for example, by taking on roommates. In this way, unfunded students might benefit from funding received by others, without the overall pool of funding increasing.

DISCUSSION

Medical students depend on funding from a variety of sources to attend AMA meetings, including their medical schools/local MSS sections, their state/specialty medical societies, and the AMA. For many members, there does seem to be outside travel funding available, and their out-of-pocket spending is modest. But there also appears to be a second population of students who would like to attend AMA meetings but do not because they do not have access to funding. While AMA has made available additional travel funding in the two years since the adoption of the policy directing this report, alternatives for funding student travel costs should be explored. This exploration must carefully consider factors such as tax implications for the AMA and for medical students and maintenance of critical ties between medical students and their Federation organizations. Additionally, AMA should pursue other means to mitigate the cost of medical student participation in AMA meetings, two of which are described here.

Attract more funding from medical schools

Policymaking is the primary focus of AMA Annual and Interim Meetings. While MSS meetings also offer some education and networking opportunities, medical school administrators still view AMA meetings as policymaking meetings. Some administrators recognize the value of this work and are willing to fund medical student participation. But most leaders in medical education seek more tangible learning outcomes to justify funding meeting attendance for their trainees—for example, the opportunity to present research or other work, well-defined leadership development opportunities, and so forth.

To that end, AMA is developing two initiatives that expand AMA meetings to better demonstrate the value of AMA meeting attendance to medical school administrators and thereby increase their likelihood of providing financial support for students to attend AMA meetings:

- In response to a request from MSS leadership, AMA reinstated an in-person Poster Showcase at the 2023 Annual and Interim Meetings, providing an opportunity for medical students to present their research while networking with and learning from their peers and leaders in health sciences research.
- Pending scheduling and availability, AMA will produce a half-day, in-person "Distinguish Yourself Student Summit." Featuring education sessions from industry leaders, workshops, networking opportunities, the continuation of the Poster Showcase described above, and more, this event will train medical students on how to be successful during their medical training and stand out from their peers in the residency application process.

Facilitate travel cost sharing

As described earlier, medical students often share meeting costs, and, more specifically, students who receive travel funding often share that funding with their unfunded peers. Unfortunately, students who are not already well connected with other MSS members at the national level typically cannot benefit from such arrangements, accentuating the disparity between involved members who are more likely to receive funding and less involved

members who do not. While it should not be viewed as an exclusive approach, AMA could potentially close this gap by facilitating travel cost sharing among MSS meeting attendees – for example, by providing a space for members to connect with potential roommates.

CONCLUSION

Medical students who attend AMA meetings receive travel funding from a variety of sources. Without this funding, many of these members would not be able to attend AMA meetings, and additional funding will be required if more medical students are to attend. AMA should promote the value of meeting attendance to incentivize institutional funding, explore opportunities for AMA to facilitate travel cost sharing among meeting attendees, explore alternate mechanisms to provide financial assistance to facilitate attendance at MSS meetings, and otherwise continue to explore mechanisms to mitigate the cost of meeting attendance for medical students.

RECOMMENDATIONS

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

1. That our AMA will promote the value of membership and meeting attendance to encourage financial support by medical schools and other funding sources.
2. That our AMA will explore mechanisms to mitigate the cost of meeting attendance for medical students.
3. That our AMA will explore alternate mechanisms to provide financial assistance to facilitate attendance at MSS meetings with a report back at the 2025 Annual Meeting.

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

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

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

The Board of Trustees has completed its review of the specialty organizations seated in the House of Delegates (HOD) required to submit information and materials for the 2024 American Medical Association (AMA) Annual Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, “Summary of Guidelines for Admission to the House of Delegates for Specialty Societies,” and AMA Bylaw 8.5, “Periodic Review Process.”

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

The following organizations were reviewed for the 2024 Annual Meeting:

American Academy of Cosmetic Surgery
American Association for Thoracic Surgery
American Association of Gynecologic Laparoscopists
American Association of Plastic Surgeons
American Association of Public Health Physicians
American College of Allergy, Asthma, and Immunology
American College of Medical Quality
American Society for Metabolic and Bariatric Surgery
American Society of Cytopathology
American Society of Interventional Pain Physicians
Association of Academic Radiology (formerly Association of University Radiologists)

Infectious Diseases Society of America
Society for Laparoscopic and Robotic Surgeons

The American Society for Reconstructive Microsurgery, American Society of Neuroimaging, and GLMA—Health Professionals Advancing LGBTQ+ Equality were also reviewed at this time because they failed to meet the requirements in June 2023.

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

The materials submitted indicate that: American Academy of Cosmetic Surgery, American Association for Thoracic Surgery, American Association of Gynecologic Laparoscopists, American Association of Public Health Physicians, American College of Allergy, Asthma and Immunology, American College of Medical Quality, American Society for Reconstructive Microsurgery, American Society of Interventional Pain Physicians, Association of Academic Radiology, GLMA—Health Professionals Advancing LGBTQ+ Equality, Infectious Diseases Society of America, and Society of Laparoscopic and Robotic Surgeons meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the AMA HOD.

The materials submitted also indicate that the American Association of Plastic Surgeons, American Society for Metabolic and Bariatric Surgery, American Society of Cytopathology, and American Society of Neuroimaging did not meet all guidelines and are not in compliance with the five-year review requirements of specialty organizations represented in the AMA HOD.

RECOMMENDATIONS

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

1. The American Academy of Cosmetic Surgery, American Association for Thoracic Surgery, American Association of Gynecologic Laparoscopists, American Association of Public Health Physicians, American College of Allergy, Asthma and Immunology, American College of Medical Quality, American Society for Reconstructive Microsurgery, American Society of Interventional Pain Physicians, Association of Academic Radiology, GLMA—Health Professionals Advancing LGBTQ+ Equality, Infectious Diseases Society of America, and Society of Laparoscopic and Robotic Surgeons retain representation in the AMA HOD.

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5, the American Association of Plastic Surgeons, American Society for Metabolic and Bariatric Surgery and American Society of Cytopathology be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership.

3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in the AMA Bylaw B-8.5 at the end of the one-year grace period, the American Society of Neuroimaging lose representation in the AMA HOD but retain it for the AMA Specialty and Service Society (SSS) and may apply for reinstatement in the HOD, through the SSS, when they believe they can comply with all of the current guidelines for representation in the HOD, in accordance with AMA Bylaw B-8.5.3.2.2.

APPENDIX

Exhibit A - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
American Academy of Cosmetic Surgery	217 of 651 (33%)
American Association for Thoracic Surgery	188 of 923 (20%)
American Association of Gynecologic Laparoscopists	1,370 of 3,663 (37%)
American Association of Plastic Surgeons	152 of 788 (19%)
American Association of Public Health Physicians	64 of 86 (74%)
American College of Allergy, Asthma, and Immunology	577 of 2,760 (21%)
American College of Medical Quality	54 of 128 (36%)
American Society for Metabolic and Bariatric Surgery	292 of 1,802 (16%)
American Society for Reconstructive Microsurgery	158 of 798 (20%)
American Society of Cytopathology	179 of 1,093 (16%)
American Society of Interventional Pain Physicians	605 of 2,816 (21%)
American Society of Neuroimaging	58 of 161 (36%)
Association of Academic Radiology	274 of 1,225 (22%)
GLMA—Health Professionals Advancing LGBTQ+ Equality	127 of 406 (31%)
Infectious Diseases Society of America	964 of 3,746 (26%)
Society for Laparoscopic and Robotic Surgeons	520 of 1,138 (46%)

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)

Policy G-600.020

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

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

Exhibit C

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

8.2.1 To cooperate with the AMA in increasing its AMA membership.

8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.

8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.

8.2.4 To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.

8.2.5 To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

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

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

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

8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

REPORTS OF THE SPEAKERS

The following reports were presented by Lisa Bohman Egbert, MD, Speaker, and John H. Armstrong, MD, Vice Speaker:

1. REPORT OF THE RESOLUTION MODERNIZATION TASK FORCE UPDATE

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies D-600.955 and G-600.045

BACKGROUND

At the 2023 Annual Meeting, resolution 604 was adopted. Resolution 604 states:

> RESOLVED, That our American Medical Association form a Speakers Task Force on the Resolution Process to review the entire process of handling resolutions for our AMA House of Delegates, including but not limited to definitions of on time resolutions, emergency resolutions, and late resolutions, deadlines for submission of resolutions by all sections, processing and review of reference committee reports, and use of virtual meetings so that all on time resolutions can be submitted by the same deadline (Directive to Take Action); and be it further
>
> RESOLVED, That our AMA Speakers Task Force on the Resolution Process report back to our AMA House of Delegates by the 2024 Annual Meeting with recommendations regarding the resolution process. (Directive to Take Action)

Pursuant to this policy, the Resolution Modernization Task Force (RMTF) was appointed by the Speaker with a broad representation in the House. The RMTF includes following nine members:

- David Henkes, MD, Chair, Texas
- Sarah Candler, MD, American College of Physicians
- Ronnie Dowling, MD, Arizona Medical Association
- Rachel Ekaireb, MD, Resident/Fellow Section, California
- Michael Hanak, MD, American Academy of Family Physicians
- Susan Hubbell, MD, American Academy of Physical Medicine and Rehabilitation
- Gary Pushkin, MD, The Maryland State Medical Society
- Kaylee Scarnati, Medical Student Section, Ohio
- Rachel Kyllo, MD, American Society for Dermatologic Surgery
- Lisa Bohman Egbert, MD, Speaker, Ohio
- John H. Armstrong, MD, Vice Speaker, American College of Surgeons

The RMTF held their initial meeting on August 27, 2023, and developed an informational report, Speakers' Report 01-I-23, which delineated issues with the resolutions process. This report was used to guide the RMTF Open Forum which was held at the 2023 Interim Meeting to solicit input from House of Delegates (HOD) and other AMA members attending the meeting. In addition, an RMTF email box was established and announced during the open forum to enable members to continue to submit comments after I-23 adjourned. There was robust discussion during the open forum and many comments were received into the RMTF email box. The discussion topics at the open forum included:

- Unequal time for delegates to evaluate items for HOD business
- Avoiding Redundancy with Existing Policy
- Reference Committee Process
- Reference Committee Hearings

The RMTF met again in early January 2024 to review comments received. As was stated at their initial meeting, the task force, "…seeks to develop efficient processes that allow for all business before the House to be equally reviewed by all delegates with the ultimate goal of the best policy being developed for our AMA," and that remained their guiding principle in developing this report and its recommendations.

DISCUSSION

Based on comments heard at the open forum, there was general consensus that the resolution process is outdated, inefficient and requires modernization. The task force notes that the resolution submission process and policies have not been changed since 2012; however, the HOD office has begun significant technical improvements to PolicyFinder and to the procedures for submission and processing of resolutions. Because these technical improvements are ongoing, the RMTF focused on changes that would allow the consideration of HOD business to be more efficient, more inclusive to members, and more equitable so that all items of business receive adequate and equivalent consideration by the House. Therefore, the proposed recommendations address resolution deadlines, the online forum, reference committee reports, and reaffirmation.

Resolution Deadlines

The resolution submission deadlines as stated in AMA Bylaws are as follows:

> 2.11.3.1 Resolutions. To be considered as regular business, each resolution must be introduced by a delegate or organization represented in the House of Delegates and must have been submitted to the AMA not later than 30 days prior to the commencement of the meeting at which it is to be considered, with the following exceptions.
>
> > 2.11.3.1.1 Exempted Resolutions. If any member organization's house of delegates or primary policy making body, as defined by the organization, adjourns during the 5-week period preceding commencement of an AMA House of Delegates meeting, the organization is allowed 7 days after the close of its meeting to submit resolutions to the AMA. All such resolutions must be received by noon of the day before the commencement of the AMA House of Delegates meeting. The presiding officer of the organization shall certify that the resolution was adopted at its just concluded meeting and that the body directed that the resolution be submitted to the AMA House of Delegates.
> >
> > 2.11.3.1.2 AMA Sections. Resolutions presented from the business meetings of the AMA Sections may be presented for consideration by the House of Delegates no later than the recess of the House of Delegates opening session to be accepted as regular business. Resolutions presented after the recess of the opening session of the House of Delegates will be accepted in accordance with Bylaw 2.11.3.1.4.
> >
> > 2.11.3.1.3 Late Resolutions. Late resolutions may be presented by a delegate prior to the recess of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.
> >
> > 2.11.3.1.4 Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates is recessed. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee. A simple majority vote of the delegates present and voting shall be required for adoption.

Currently, it is difficult for staff, delegations and members to review and fully vet all items of business before the House due to the multiple exceptions to the "on-time" deadline as defined above. These multiple exceptions mean that business is being processed in an ongoing fashion and results in a fairly significant amount of "on-time" business being submitted after the 30-day deadline through the closing of the HOD Opening Session. Although exempted resolutions are posted on the website as soon as they are processed, they are not able to be included in the HOD Delegate Handbook or the Online Member Forums (forums) and are often not seen by delegations until the release of the "meeting tote" prior to the HOD Second Opening Session. These items of business are not available to undergo the same consideration as those submitted before the 30-day deadline. The inability to adequately review

these late arriving “on-time” resolutions has been identified as a major frustration by delegations. The short timeframe for review also limits opportunities for collaboration and consensus building among delegations. Many suggestions to rectify this problem were offered at the open forum and by email. The majority favored having one set “on-time” deadline. Some delegates voiced concern for the Sections who meet and pass resolutions just prior to the meeting. However, representatives from the MSS and RFS stated that they have a very robust process for vetting their resolutions; by default, resolutions are deferred to the following HOD meeting, and only those of an urgent nature are immediately forwarded. Given that late resolutions are specifically reviewed for their timeliness and urgency, these resolutions would be well positioned to be recommended for consideration if submitted as such.

Therefore, the RMTF recommends that the “on-time” deadline for resolutions be set at 45 days prior to the commencement of the meeting at which it is to be considered. This recommendation discontinues the exemptions for late society meetings and AMA Sections. Resolutions will be considered “late” when received after the 45-day deadline and prior to the beginning of the HOD Opening Session. Late resolutions will continue to be under the purview of the Rules and Credentials Committee and the criteria for which late resolutions would be recommended for consideration will continue to include the resolution’s timeliness and the urgency of the topic. Recommendations for consideration of late resolutions will continue to be included as a consent calendar on the Rules and Credentials Report presented at the Second Opening Session and require a two-thirds vote for consideration. The emergency resolution process would remain unchanged; however, any resolution submitted after the HOD Opening Session begins will be treated as an emergency resolution.

In summary, resolutions will fall into one of three categories: on time (45 days prior to the meeting), late (after the on-time deadline and before the Opening Session begins), or emergency (after the Opening Session begins). The Sections and organizations that hold their policy-making meetings after the on-time deadline would be encouraged to review their resolutions for timeliness and urgency and hold those not meeting this criteria for the next coming AMA meeting. Those resolutions deemed timely and urgent could be submitted as late resolutions which will require a two-thirds vote for consideration. These adjusted deadlines would allow staff to more easily process items of business, prepare and post the HOD Delegate Handbook in its entirety, and post the entire handbook on the Online Member Forums. In turn, this should allow delegations more time to consider items of business without the scramble and frustration that the current process produces. Overall, these changes will level the playing field so that all resolutions will be able to be reviewed equally.

Reference Committees Hearings and Reports

The Online Member Forums were identified as an area ripe for improvement. Many commenters noted experience from their own organizations in which a more robust virtual preliminary reference committee process led to a more efficient in-person process and ultimately to policy that has been more thoughtfully crafted and more thoroughly vetted. Additionally, Res. 606-I-21, established policy D-600.956 which called for a two-year trial requiring that reference committees, prior to the in-person reference committee hearing, produce a preliminary reference committee document based on the written online testimony. An evaluation to determine if this procedure should be continued is a directive of this policy. The RMTF was asked to conduct this evaluation as part of their overall review to modernize the HOD.

Assessing the success of the trial of the Online Member Forums is difficult. As noted above, the vast majority of the comments submitted to the RMTF suggested that these online forums should be utilized in a much more robust and productive way to move the business of the HOD forward. Polling of HOD delegates over a course of three meetings (A-22, I-22 and A-23), found that consistently around 70% of delegates had viewed at least a few items on the forums. The preliminary documents were found to be at least “somewhat helpful” by around 65% of those responding. This would suggest that, although delegates find the forums to be a useful tool to review items of business, they are currently being underutilized.

In their current state, the comments received on the forums are viewed by many to not carry the same importance as in person testimony which is multifactorial in origin. A significant factor, as discussed above, is that many “on-time” resolutions are not even posted on the forums. In addition, the current process for developing a preliminary document, as defined in policy D-600.956, gives very little insight into the direction of the reference committee’s actions. By explicitly treating this as an official reference committee hearing with a report, the RMTF believes this will drive greater utilization of this valuable tool by elevating the importance of contributing to the online discussion. This change would thus give equal weight to the testimony gathered online. In addition, there are multiple advantages to online testimony which include:

- The ability to submit amendments and/or supporting documentation with unlimited text which allows for consideration and comment by other delegations.
- More time and opportunity for delegates and delegations to collaborate to improve proposed resolutions.
- The opportunity for the entire AMA membership to submit comments, offering a wider voice in the development of AMA policy.
- Increased inclusivity by allowing those unable or who prefer not to travel to meetings the opportunity to participate.
- The opportunity for small delegations to provide input on all items of business by avoiding the inherent difficulty of presenting at concurrent in-person reference committee hearings.

Therefore, the RMTF recommends that the Online Member Forums be renamed the Online Reference Committee Hearings. These online ref coms will open 10 days following the 45-day resolution submission deadline and be open for 21 days. As noted above, this 10-day window will allow adequate time for staff processing of resolutions, the development of the HOD Handbook, the review of the Resolution Committee for Interim, and the posting of resolutions on the Online Reference Committees which currently is a lengthy process. This also extends the online ref coms by one week beyond the current two-week window. For these reasons, the RMTF chose 45 days for the "on-time" deadline. All items of business received by the resolution deadline will be included in the Online Reference Committee Hearings.

The RMTF recommends that reference committees convene virtually after the online ref com 21-day window closes, to develop a Preliminary Reference Committee Report. The task force further recommends that the bylaws be amended so that the term for all committees of the House shall commence upon their formation and shall continue throughout the meeting for which they were appointed unless otherwise directed by the HOD, such as Reference Committee F.

The Preliminary Reference Committee Report will follow the same format as the reference committee reports which are produced following the in-person hearings with the exception that they shall not be consent calendars. The reports would include recommended actions by the reference committee with items grouped by action, a summary of testimony to date, and a rationale for the action recommended. The reports would be posted to the HOD website at least four days prior to the opening of the HOD meeting for which they were submitted.

The in-person reference committee hearings will continue to hear testimony on each item before the reference committee with the exception that the order of business would follow the order listed on the Preliminary Reference Committee Report. Therefore, those items recommended for adoption would go first followed by those recommended for adoption as amended and so forth, with items for reaffirmation in lieu of being heard last. Although the preliminary reports will offer recommendations for action for each item, this does not preclude discussion of the original item and/or alternate actions or the submission of supporting documentation for the reference committee to consider. Following the in-person hearing, the reference committees will convene to review the in-person testimony and make necessary adjustments to their reports taking both online ref com and in-person testimony into consideration. The final reference committee report to be considered at the HOD will then be posted in the usual fashion.

In prior discussions of preliminary reports, concerns included that recommendations contained in the report would be based on insufficient input or include recommendations that bias the outcome of an item of business. However, those with experience with such a preliminary report with recommendations noted that the inclusion of recommendations actually led to more robust online discussions and thus more accurate initial recommendations. Additionally, as previously stated, the recommendations included in the preliminary report are based on initial testimony only and would be updated to reflect the totality of testimony from both the online and in-person testimony and that stating a preliminary action does not preclude discussion of the original item or alternative actions at the in-person hearing. Reference committee members should be trusted to incorporate in-person testimony and change recommendations as warranted.

The task force believes this iterative process affords delegates and delegations the time to collaborate on language and to fully review topics that are more complicated in nature and provides the opportunity to perfect reference committee recommendations for their final report. Ultimately, reference committee reports are not definitive until the House acts, and this process provides ample opportunity to discuss each item of business to achieve the goal of developing the best possible policy of our AMA.

Reaffirmation

The reaffirmation process was universally identified as a significant problem to be addressed and was generally described as "broken." This was highlighted at I-23 when all of the items placed on the consent calendar were subsequently removed from it. In their discussions, the task force identified some of the sources of items recommended for reaffirmation which include:

- Policy exists but the authors are either not aware of the policy or current AMA activity to achieve the goals of the existing policy.
- Some delegations have a directive to their delegation from their parent organization to submit all resolutions earmarked to go to the AMA for consideration, even when they are aware that there is current existing policy.
- There is current AMA policy on the subject, but authors are not satisfied with AMA activity as a result of the existing policy.

The task force noted that many members consider reaffirmation a "defeat" of their resolution. On the contrary the task force believes that reaffirmation should be seen as a "win" as it resets the sunset clock and brings the issue back to the attention of our leadership and management team.

The RMTF spent significant time discussing the current process and potential improvements for it. Ultimately, the task force decided that the current process of having resolutions placed on a reaffirmation calendar should be discontinued and that the recommended firm on-time deadline along with the implementation of the online ref coms with subsequent preliminary reports, would be the best method to handle the identification of items for reaffirmation. As envisioned, the process would be as follows: AMA content experts would continue to review submitted resolutions and identify relevant current policy which is included as background information. These policies would also be posted on the online reference committee hearing and, when appropriate, a notation would be added that an identified policy may be reaffirmed in lieu of the resolution. Online comments regarding these so identified items could then proceed regarding the merits of reaffirmation along with the merits of the item itself. The reference committee will then have the option to recommend "reaffirmation in lieu of" for these or any other item it deems appropriate on its preliminary reference committee report. Further discussion of the handling of these items will then be entertained at the in-person hearing.

CONCLUSION:

The RMTF recommends the establishment of a firm deadline of 45 days prior to the start of a meeting for on-time resolutions with all resolutions received after this deadline and prior to the start of the meeting considered late. This strict deadline will allow for all on-time resolutions to be included in the Online Reference Committee Hearings (renamed from the Online Member Forums) and for these online ref coms to remain open for 21 days rather than the current 14. The online ref coms will produce Preliminary Reference Committee Reports which will include preliminary recommendations. Recommendations regarding reaffirmation in lieu of a resolution will be included in the Preliminary Reference Committee Report rather than a reaffirmation calendar so that comments regarding reaffirmation can be made in the online ref coms and discussed further at the in-person hearings. Delegations and Sections that meet after the 45 day on-time deadline will have the opportunity to present late resolutions which they deem timely and urgent to the Rules and Credentials Committee which will in turn recommend for or against consideration based on these criteria. These changes will allow for equal consideration of all on-time resolutions as well as equal application of the timeliness and urgency considerations for all late resolutions. It will eliminate the current "broken" reaffirmation process and allow for open discussion of the merits of reaffirmation on any given item.

The objective of the task force was to increase the efficiency of the resolution process but also paramount was to maintain member input and the voice of the minority. The task force tried to individually look at each of the issues identified at the town hall meeting and the email box but found that the issues and solutions were integrated. Your task force believes that all of the proposed recommendations work together to provide the fairest, most effective, and efficient manner to develop the best policy for our AMA. The RMTF expresses the need for caution in that changes in one recommendation may reduce the effectiveness of others and urges the House to accept the proposed recommendations in aggregate to achieve these goals.

RECOMMENDATIONS:

The Resolution Modification Task Force recommends that the following be adopted to be implemented for Interim 2024 and the remainder of the report be filed:

1. The bylaws be amended so that the resolution submission deadline be 45 days prior to the opening session of the House of Delegates with AMA Sections excluded from this deadline.

2. The bylaws be amended so that the definition of a late resolution shall be all resolutions submitted after the resolution submission deadline with AMA Sections excluded from the deadline and prior to the beginning of the Opening Session of the House of Delegates.

3. The bylaws be amended so that the definition of an emergency resolution shall be all resolutions submitted after the beginning of the Opening Session of the House of Delegates.

4. The bylaws be amended so that the term of committees of the House of Delegates shall commence upon their formation and shall conclude at the end of the meeting for which they were appointed, unless otherwise directed by the House of Delegates.

5. That our AMA will convene Online Reference Committee Hearings prior to each House of Delegates meeting. These hearings shall open 10 days following the resolution submission deadline and remain open for 21 days. This shall be accomplished in lieu of Policy G-600.045.

6. Prior to House of Delegates meetings, reference committees will convene after the close of the Online Reference Committee Hearings to develop a Preliminary Reference Committee Report. These reports shall include preliminary recommendations and will serve as the agenda for the in-person reference committee hearing. This shall be accomplished in lieu of Policy G-600.060(8).

7. That Policy D-600.956 be rescinded.

Relevant AMA Policy:

Increasing the Effectiveness of Online Reference Committee Testimony Policy D-600.956
1. Our AMA will conduct a trial of two-years during which all reference committees, prior to the in-person reference committee hearing, produce a preliminary reference committee document based on the written online testimony.
2. The preliminary reference committee document will be used to inform the discussion at the in-person reference committee.
3. There be an evaluation to determine if this procedure should continue.
4. The period for online testimony will be no longer than 14 days.
5. The trial established by Policy D-600.956 be continued through Annual 2024.

Online Member Forums in the House of Delegates G-600.045
1. Online member forums should be incorporated into every House of Delegates policymaking meeting, using the following parameters: a. Each reference committee should participate in the online member forum process; b. Each online member forum should cover as many items of business as possible, including, at minimum, those items that appear in the initial compilation of the Delegate Handbook; c. Comments submitted to an online member forum should be used to prepare a summary report that reflects the comments received up to that point; d. Full, free and complete testimony should be allowed in the onsite hearings; and e. The Speakers should experiment with alternative procedures to enhance and improve the overall online member forum process.
2. Our American Medical Association will form a Speakers Task Force on the Resolution Process to review the entire process of handling resolutions for our AMA House of Delegates, including but not limited to definitions of on time resolutions, emergency resolutions, and late resolutions, deadlines for submission of resolutions by all sections, processing and review of reference committee reports, and use of virtual meetings so that all on time resolutions can be submitted by the same deadline.
3. Our AMA Speakers Task Force on the Resolution Process will report back to our AMA House of Delegates by the 2024 Annual Meeting with recommendations regarding the resolution process.

Introducing Business to the AMA House G-600.060
AMA policy on introducing business to our AMA House includes the following:
1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website.
2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement.
3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process.
4. At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution.
5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which he or she considers significant or when requested to do so by the organization, and the actions taken in response to such contacts.
6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates.
7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House.
8. Resolutions will be placed on the Reaffirmation Consent Calendar when they are identical or substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy Database identification number. When practical, the Reaffirmation Consent Calendar should also include a listing of the actions that have been taken on the current AMA policies that are equivalent to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the submitted resolution which resets the sunset clock for ten years.
9. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is made available to the House.

2. REPORT OF THE ELECTION TASK FORCE 2

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

BACKGROUND

At the 2023 Interim Meeting, the Election Task Force 2 (ETF2) submitted Speakers' Report 3-I-23 which included multiple recommendations, many of which were ultimately referred back. The ETF2 subsequently met February 10, 2024, to review these items and testimony heard at I-23. The task force will hold an open forum on Sunday, June 9, 2024, at 3:00 pm CT to gather additional feedback on these items and will then develop a report with final recommendations to be presented at Interim 2024. The topics of consideration listed on this report will be the basis for discussion at the open forum.

ITEMS FOR DISCUSSION

The ETF 2 noted that there was a general lack of clear definitions related to items surrounding AMA elections. Therefore, they developed the definitions in the Glossary shown below. In addition, the ETF 2 reviewed all items that were referred back for further consideration and suggested changes shown as additions and deletions and the

rationale for these suggestions in the grid that follows. The ETF 2 asks that delegations review and make comments on the Glossary and Proposed Changes at the Open Forum.

The final topic for consideration at the open forum will be a consideration of endorsements. This will be an open topic and all input is encouraged.

Glossary

Active campaign window – period of time after the speaker's notice of the opening of active campaigning until the Election Session during the House of Delegates meeting at which elections are being held

Active campaigning – Outreach by candidates or their surrogate(s), including but not limited to members of their campaign team, to members of the House of Delegates with the goal of being elected by the AMA House of Delegates

Announced candidate – person who has indicated their intention to run for elected position; announcement can be made only by sending an electronic announcement card to the Speakers via the HOD office by email to hod@ama-assn.org

Campaign manager(s) – person(s) identified by the candidate to the HOD Office as the person(s) responsible for running the campaign
Campaign team – campaign manager(s) and/or staff identified by the candidate to the HOD Office

Campaign-related – any content that includes reference to an announced candidate in the context of their candidacy for an elected position within the AMA

Digital – relating to, using, or storing data or information in the form of digital signals; involving or relating to the use of computer technology; this includes but is not limited to social media and communication platforms

Elected position(s) – Council or Officer position within the AMA elected by the House of Delegates of the AMA

Featured – identification of a candidate at an event by the host or organizer of the event including but not limited to written or verbal announcement of the candidate or their candidacy

ETF 2 Proposed Language ***(Proposed changes to current policy or items from ETF 2 I-23 report shown in red)***	**Rationale**
Proposed changes to current policy: Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, AMA, 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.	ETF2 considered the testimony from the delegates during the I-23 meeting. In order to confine to the security requirements for the meeting badges, no buttons, pins or stickers can be affixed to the badge itself. AMA, AMPAC, AMA-Foundation, specialty society, state or regional delegations pins, buttons, stickers, etc. are not directly connected to the election campaign and thus can be worn on one's self except on the badge. This proposal is intended to avoid uneven general exposure to a particular candidate and will provide an even playing field for all candidates.

ETF 2 Proposed Language ***(Proposed changes to current policy or items from ETF 2 I-23 report shown in red)***	**Rationale**
New language referred at I-23 with proposed changes. ~~Only a~~An announced candidate in a currently contested election may discuss their candidacy on an individual basis in private conversations from announcement of candidacy until the active campaigning period begins. Prior to the active campaigning period, no other individual may discuss the candidacy ~~including members of campaign teams, delegations or caucuses, and "friends."~~ This rule does not prohibit any candidate from discussions for the purpose of forming a campaign team nor from a campaign team discussing a candidate or campaign strategy. This rule also does not prohibit persons not associated with a campaign from discussing candidates in private conversations.	The intent here is to minimize campaign discussions prior to active campaigning. However, the ETF2 was aware of concerns that this rule would prohibit candidates from asking others to join their campaign team as well as prohibiting a designated campaign team from discussing campaign strategy. This clarifies that both are expected and permitted.
Proposed changes to current policy: Printed and digital ~~C~~campaign materials may not be distributed to members of the House other than by the HOD office candidate email and on the Candidate Web Pages. ~~by postal mail or its equivalent~~. The AMA Office of House of Delegates Affairs will not ~~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~~.	In order for candidates to have equal access to HOD members, the route of access to them is limited to the official AMA channels noted here. This will discourage additional printed mailings and digital communications and disallow distribution at the HOD meetings.
Proposed changes to current policy: Active campaigning via mass outreach to delegates by candidates or on behalf of a candidate by any method is prohibited. A reduction in the volume of campaign-related telephone calls and personal electronic communication from candidates and on behalf of candidates is encouraged. No part of this rule shall be interpreted to limit communication among members of a campaign team. ~~The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of e~~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.	The ETF2 seeks to clarify guidelines for communication by candidates to other delegates. New language has been added to specifically prohibit mass outreach to candidates. However, this recommendation also clarifies that personal communication is allowed, while simultaneously honoring the desire of many delegates to reduce overall volume of communication. A clarification was added to ensure freedom of communication amongst campaign teams. Language was also revised to reflect the frequency of electronic communication while still maintaining the option to opt out.

ETF 2 Proposed Language ***(Proposed changes to current policy or items from ETF 2 I-23 report shown in red)***	**Rationale**
Proposed changes to current policy: Groups conducting interviews with announced 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 finalize~~ announced candidates at the time the group's interview schedule is finalized. a. A group may meet with an announced candidate who is a member of their group during the active campaign window without interviewing other candidates for the same office. b. Interviewing groups may, but are not required to, interview ~~late announcing candidates~~ persons who become announced candidates during the active campaign window. 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. c. ~~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.~~ Any ~~appearance~~ campaign-related presentation to an assembly by an announced candidate, with or without being followed by a discussion, question and answer session, or a vote of the assembly regarding the candidate, is an interview and subject to the rules on in-person interviews. No portion of this rule shall be interpreted to mean that a candidate acting in a formal capacity would be unable to present or discuss matters pertaining to that formal capacity with any group.	The Election Task Force heard concerns about definitions of timelines, candidacy, and potential election violations that would be incurred by delegations meeting with their own members who happened to be candidates. The proposed language here seeks to clarify that there is no restriction on a delegation's ability to hold meetings where all of their members may be in attendance. Further, the Election Task Force wanted to clarify the mechanism for candidates that do not announce until after the active campaign window opens may be offered interviews, and what this means for all other candidates for that same office. Finally, there were questions about what constitutes an interview and how candidates holding an official AMA position while running for office could execute their duties without being considered participating in an interview. This section provides clarity about this definition and the separation of a candidate campaigning and a member performing in their official capacity.
New language referred at I-23 with proposed changes. Candidates may not produce a personal campaign-related website or other digital campaign-related content or direct to personal or professional websites that contain campaign materials other than the AMA Candidates' Page.	The language in this section provides clarity that explicitly defines that the only authorized campaign or digitally related websites, pages, or other campaign related materials for candidates is a web page provided by the AMA. This allows all candidates to be on equal footing during the election process.

ETF 2 Proposed Language ***(Proposed changes to current policy or items from ETF 2 I-23 report shown in red)***	**Rationale**
Proposed changes to current policy: Active campaigning for ~~AMA elective office~~ an elected position may not begin until the active campaign window opens as announced by the Speaker.~~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.~~	The Election Task Force heard questions concerning timelines for active campaigning in the course of an Election cycle. Active Campaigning is defined as outreach by candidates or their surrogate(s), including but not limited to members of their campaign team, to members of the House of Delegates, with the goal of being elected by the AMA House of Delegates. Active Campaigning activities typically may not occur until after the April meeting of the Board of Trustees, when candidates for Council Seats are announced. The specific dates of the Active Campaigning Window will be announced by the Speaker. The Active Campaigning Window is defined as the period of time after the Speaker's notice of the opening of active campaigning until the Election Session during the House of Delegates meeting at which elections are being held.
New language referred at I-23 with proposed changes. Candidates ~~and their identified members of campaign teams~~ will be provided a copy of the current election rules and will be required to attest to abiding by them. Candidates are responsible for any and all action or inaction undertaken on their behalf that is campaign related. Campaign managers will also be provided a copy of the current election rules and will be required to attest to abiding by them.	While all HOD members should be aware of the current election rules, candidates are ultimately responsible for abiding by these rules and for all campaign related actions taken on their behalf. Therefore, candidates and their campaign managers will be asked to attest to abiding by these rules.
New item referred at I-23 (shown below) with proposed new language: All meeting attendees will agree to be interviewed by the Speakers or members of the Election Committee for the purpose of investigating a submitted, formal complaint of election rule infractions. Members of the Election Committee, including the Speakers, will identify themselves and the reason for the interview request. *[Referred language:* *Candidates, members of their campaign teams, including Federation staff, and HOD members will agree to be interviewed by the Speakers or members of the Election Committee who will identify themselves and the reason for the request.]*	As part of any investigation, including a simple inquiry as to whether a formally filed complaint has merit to warrant a more complete evaluation, it is important that all attendees (including delegation leadership and staff) assist by complying with a request for an interview with the Speakers or member(s) of the Election Committee, as well as that interviewers clearly identify themselves and the reason for any interview. Cooperation of all attendees would be expected and beneficial to our HOD. This recommendation arises out of prior experience by the Election Committee in trying to evaluate complaints.

3. UPDATED PARLIAMENTARY AUTHORITY

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Recently, the American Institute of Parliamentarians Standard Code of Parliamentary Procedure, was updated and is now referenced as AIPSC (2nd ed.), with changes taking effect in January of 2024. AMA Bylaw 11.1, Parliamentary Procedures, last amended in 2015, states that "In the absence of any provisions to the contrary in the Constitution and these Bylaws, all general meetings of the AMA and all meetings of the House of Delegates, of the Board of Trustees, of Sections and of councils and committees shall be governed by the parliamentary rules and usages contained in the then current edition of The American Institute of Parliamentarians Standard Code of Parliamentary Procedure."

When the AMA House of Delegates (HOD) adopted AIPSC as its parliamentary authority in 2015, there were only minor differences between it and AMA's past parliamentary practices and traditions as embodied in the *HOD Reference Manual.* These were discussed in detail in Speakers Report 1-A-16, which was adopted by the HOD. Adoption allowed the HOD to retain some historical parliamentary practices and traditions, including requiring debate on both sides prior to closing debate on a subject, separate motions of refer for report and refer for decision (AIPSC uses a single motion of refer), the motion to table, and AMA's historical practice of considering all matters acted upon at a meeting to be final, meaning that items from one meeting are not subject to a motion to recall from committees, a motion to reconsider or any other motion at a subsequent meeting. Adoption also created the motion to Object to Consideration requiring a 3/4 majority vote. Specific AMA bylaws focusing on withdrawal of resolutions, also remained in place: 2.11.3.1.5 allows a sponsor to withdraw a resolution at any time prior to its acceptance as business by the HOD, and 2.13.1.7.4, which provides that if, in the judgment of the sponsor and of the reference committee, it appears that withdrawal is preferable to presentation for action, the reference committee may recommend withdrawal to the HOD in its report, with the Proceedings noting only that the resolution was withdrawn. Adoption of Speakers Report 1-A-16 also led to subsequently amended and adopted bylaws related to late and emergency resolutions.

The Speakers, in concert with the Council on Constitution and Bylaws, have reviewed the AIPSC (2nd ed.) and compared the rules therein to usual practice in the House of Delegates and in the *House of Delegates Reference Manual: Procedures, Policies and Practices*. The *HOD Reference Manual* delineates the HOD's Standing Rules, and is presented in a Rules Report that is adopted by the HOD at each meeting by majority vote, with the Rules Report stating that the *HOD Reference Manual* shall be the official method of procedure in handling and conducting the business of the AMA House of Delegates. [The AIPSC (2nd ed.) is available for purchase on Amazon in Kindle and print versions.]

AIPSC (2nd ed.) identified the following as among the substantive changes:

- Replacing the concept of restricted debate with a requirement that debate be germane to the motion at hand. (No change required as this is current AMA practice. Note, this would also be inclusive of motions to refer, reconsider and postpone debate.);
- Making Close Debate and Vote Immediately amendable as to the motions to which it applies. **(Rather than making the motion amendable, your Speakers have elected to continue our current AMA practice in which the maker of the motion may specify to which items they wish to apply the motion with the caveat that both sides must have been heard on each item)**;
- Removing the debatability of motions that limit debate. **(The motions Object to Consideration* and Limit or Extend Debate will no longer be debatable)**;
  **The motion Object to Consideration requires a ¾ vote and is unique to the AMA. This was adopted by the HOD at A-16. However, as it limits debate, it will no longer be debatable.*
- Removing the concept of a substitute amendment. (No change required as current AMA practice treats substitute amendments as motions to adopt in lieu of);
- Establishing that after debate has been closed, Factual Inquiries are not permitted, although a Parliamentary Inquiry may be. **(This rule will be implemented)**;

- Clarifying the methodology and motions used to create a continued meeting. (No change required as AMA items of business are not held over for future meeting);
- Some Main Motions have been retitled as Specific-Purpose Main Motions. (Retitled appropriately on the HOD Reference Manual's Parliamentary Quick Tips Chart, which is appended to this report);
- Special Orders were renamed Scheduled Orders. (Not applicable);
- Standing Rules are now designated as "Standing Rules of Order" or "Temporary Rules. **(The House of Delegates Reference Manual constitutes our Standing Rules of Order. These are highlighted in the Rules Report along with any Temporary Rules for that meeting.)**;
- Clarifying rules related to the Credentials Committees, whereby the initial Credentials Committee lists the names of members entitled to vote. (Not applicable as the current AMA practice is to identify credentialed delegates in "The Official Call" with the Committee on Rules and Credentials reporting each day only the number of credentialed delegates in attendance and whether a quorum has been met. The HOD Proceedings reflect the final listing of members of the HOD.)

The nuances of these changes are addressed in the *HOD Reference Manual* and incorporated into the "Parliamentary Quick Tips" chart that appears as an appendix in the HOD Reference Manual and which is attached to this report also. The Rules Report, to be presented at A-24, will once again ask the HOD to adopt the *HOD Reference Manual* as the official method of procedure in handling and conducting the business of the AMA House of Delegates.

There also are several other changes that require additional action: AIPSC (2nd ed.) establishes electronic notice (of a meeting) as the default notification and there are several bylaw provisions (2.12.2, 2.12.3.1, 5.2.4, 5.2.4.1 and 12.3) that specify notification by mail or in writing. The Council has submitted amended bylaw language via CCB Report 4-A-24, AMA Bylaw Amendments Pursuant to AIPSC (2nd ed.).

RELEVANT AMA BYLAWS

2.12.2 Special Meetings of the House of Delegates. Special Meetings of the House of Delegates shall be called by the Speaker on written or electronic request by one third of the members of the House of Delegates, or on request of a majority of the Board of Trustees. When a special meeting is called, the Executive Vice President of the AMA shall mail a notice to the last known address of each member of the House of Delegates at least 20 days before the special meeting is to be held. The notice shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the meeting is called.

2.12.3.1 Invitation from Constituent Association. A constituent association desiring a meeting within its borders shall submit an invitation in writing, together with significant data, to the Board of Trustees. The dates and the city selected may be changed by action of the Board of Trustees at any time, but not later than 60 days prior to the dates selected for that meeting.

5.2.4 Notice of Meeting. Notice is given if delivered in person, by telephone, mail, or any means of electronic communication approved by the Board of Trustees. Notice shall be deemed to be received upon delivery to the Trustee's contact information then appearing on the records of the AMA.

5.2.4.1 Waiver of Notice. Notice of any meeting need not be given if waived in writing before, during or after such meeting. Attendance at any meeting shall constitute a waiver of notice of such meeting, except where such attendance is for the express purpose of objecting to the transacting of any business because of a question as to the legality of the calling or convening of the meeting.

12.3 Articles of Incorporation. The Articles of Incorporation of the AMA may be amended at any regular or special meeting of the House of Delegates by the approval of two-thirds of the voting members of the House of Delegates registered at the meeting, provided that the Board of Trustees shall have approved the amendment and submitted it in writing to each member of the House of Delegates at least 5 days, but not more than 60 days, prior to the meeting of the House of Delegates at which the amendment is to be considered.

Appendix B: Parliamentary Quick Tips

Adapted from AIPSC (2nd ed.) for AMA House of Delegates

Table of Precedence of Motions

Types of motions are listed in order of precedence from highest to lowest. A second motion cannot be accepted unless it has a higher precedence than the motion already before the group.

Type of Motion			Procedures				
			May Interrupt Speaker?	Requires a Second?	Is motion debatable?	May be Amended?	Vote Needed?
	Privileged	Adjourn the meeting	No	Yes	No	Yes	Majority
		Recess the meeting	No	Yes	No	Yes	Majority
		Question of privilege[1]	Yes	No	No	No	None
	Subsidiary	Object to consideration[2]	No	Yes	No	No	Three-fourths
		Table**	No	Yes	No	No	Two-thirds
		Close debate and vote immediately	No	Yes	No	No	Two-thirds
		Limit or extend debate	No	Yes	No	Yes	Two-thirds
		Postpone to a certain time	No	Yes	Yes	Yes	Majority
		Referred for decision[3]	No	Yes	Yes	Yes	Majority
		Referred for report	No	Yes	Yes	Yes	Majority
		Amend	No	Yes	Yes	Yes	Majority
	Main	a. The main motion (introduce)	No	Yes	Yes	Yes	Majority
		b. Specific-purpose main motions:					
		Adopt in lieu of	No	Yes	Yes	Yes	***
		Reconsider	Yes*	Yes	Yes	No	Majority
	Incidental	**Motions**					
		Appeal a decision by the Speaker	Yes	Yes	Yes	No	Majority
		Suspend the Rules	No	Yes	No	No	Two-thirds
		Requests					
		Point of order[4]	Yes	No	No	No	None
		Inquiries[5]	Yes	No	No	No	None
		Division of question	No	No	No	No	None
		Division of House	Yes	No	No	No	None

Definitions:

[1] Question of privilege: Raising a question of privilege allows a single member to request immediate action affecting safety, health, security, comfort, or integrity, including the rights and privileges of a member or members or of the HOD generally.

[2] Object to consideration: Per HOD action at A-16, this motion is unique to the AMA and is used when a delegate objects to HOD consideration of an item. It cannot interrupt a speaker, requires a second, cannot be amended and takes precedence over all subsidiary motions and cannot be renewed. It requires a ¾ vote. However, per AIPSC (2nd ed.) as it limits debate, it will no longer be debatable.

[3] Refer for decision: Per HOD action at A-16, this motion is used when a delegate wants the Board to determine the appropriate course of action and proceed, and report back on its decision and the action taken. It is one step higher in precedence than the Motion to Refer.

[4] Point of order: A point of order calls to the attention of the Speaker and the HOD an alleged violation of the rules, an omission, a mistake, or an error in procedure and secures a ruling on the question raised.

[5] Inquiries: An inquiry allows a member (1) to ask the Speaker a question relating to procedure in connection with the pending motion or with a motion the delegate may wish to bring immediately before the HOD (Parliamentary Inquiry); or (2) to request substantive

information or facts about the pending motion or for information on the meaning or effect of the pending question from the Speaker or a delegate (Factual Inquiry)

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* May interrupt the proceedings but not another speaker
** In order only after item is referred to reference committee and until the House takes final action on the item
***Same vote as required for original item. For example, if the motion related to a bylaw change that required a two-thirds vote, the motion to adopt in lieu of would require the same.