

## **Informational Reports**

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## REPORT OF THE BOARD OF TRUSTEES

B of T Report 01-A-24

Subject: Annual Report

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

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

## REPORT OF THE BOARD TRUSTEES

B of T Report 03-A-24

Subject: 2023 Grants and Donations

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

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

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

<b>Funding Institution</b>	<b>Project</b>	<b>Amount Received</b>
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
<b>Government Funding</b>		<u><b>2,810</b></u>
The Physicians Foundation, Inc.	American Conference on Physician Health	28
<b>Nonprofit Contributors</b>		<u><b>28</b></u>
Nuance Communications, Inc.	American Conference on Physician Health	12
Contributors less than \$5,000	International Medical Graduates Section Reception	3
<b>Other Contributors</b>		<u><b>15</b></u>
<b>Total Grants and Donations</b>		<b>\$ <u><u>2,853</u></u></b>

# REPORT OF THE BOARD OF TRUSTEES

B of T Report 05-A-24

Subject: Update on Corporate Relationships

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

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1 PURPOSE

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

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9 BACKGROUND

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

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18 YEAR 2023 RESULTS

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

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26 CONCLUSION

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28 The Board of Trustees (BOT) continues to evaluate the CRT review process to balance risk  
29 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

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
21890	<b>March of Dimes Gourmet Gala</b> - 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	<b>Bryce Harlow Foundation 42nd Annual Awards Dinner</b> – 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	<b>HIMSS Global Health Conference &amp; Exhibition</b> - Repeat sponsorship with AMA and CPT names and logos.	Health Information and Management Systems Society	02/02/2023
22011	<b>Public Relations Student Society of America Midwest District Conference</b> – Sponsorship with AMA name and logo.	Public Relations Student Society of America Public Relations Society of America	02/06/2023
22026	<b>NAMSS 47th Annual Educational Virtual Conference and Exhibition</b> - 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	<b>AHCJ Conference</b> – Repeat sponsorship with AMA and JAMA Network names and logos.	Association of Healthcare Journalists	02/08/2023
22132	<b>IAIABC 109th Convention</b> - 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 Healthsystems Official Disability Guidelines by Milliman Clinical Guidelines Enlyte Ebix Verisk Tybera HealthTech, Inc Rising Medical Solutions	02/14/2023
22123	<b>AAPC HEALTHCON Events</b> - Repeat sponsorship with AMA name and logo.	American Academy of Professional Coders	02/15/2023
22064	<b>National Rx &amp; Illicit Drug Summit</b> - 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	<b>AMA Research Challenges-</b> AMA branded competition repeat event with Laurel Road sponsored prize.	Laurel Road Bank Key Bank	02/17/2023

22283	<b>National Black Law Students Association Convention</b> – Sponsorship with AMA name and logo.	National Black Law Students Association Haynes Boone Holland & Knight Alston & Bird	02/24/2023
22121	<b>Becker’s Collaborations</b> - Webinar, CEO & CFO Roundtables and Luncheon, and Annual Hospital Review.	Becker’s Hospital Review ASC Communications	02/24/2023
22194	<b>ViVE 2023 Sponsorship</b> – Repeat sponsorship with AMA name and logo.	HLTH Inc College of Healthcare Information Management Executives (CHIME)	03/02/2023
22323	<b>Rock Health Summit</b> – 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	<b>AMA International Medical Graduates Section (IMGS) Annual Meeting Desserts Reception</b> – 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	<b>NLGJA: The Association of LGBTQ Journalists Annual Conference</b> – 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	<b>Chicago Cares - Find your Cause Event</b> – Sponsorship with AMA name and logo.	Chicago Cares	03/15/2023
22462	<b>National Hispanic Medical Association 26th Annual Conference</b> – Repeat sponsorship with AMA name and logo.	National Hispanic Medical Association	03/17/2023
22454	<b>Asian American Journalists Association’s Annual Convention</b> – Repeat sponsorship with AMA name and logo.	Asian American Journalists Association	03/20/2023
22540	<b>Credentialing State Shows</b> – 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	<b>Reuters Digital Health, Reuters Momentum Events</b> – Conference sponsorships with AMA name and logo.	Reuters Events	04/04/2023
22697	<b>AMA Medical Education AAMC Webinar</b> – Co-branded sponsorship with AMA name and logo.	Association of American Medical Colleges	04/14/2023

22707	<b>National Independent Laboratory Association Annual Meeting</b> – Repeat sponsorship with AMA name and logo.	Agena Bioscience Seegene Technologies Streamline Scientific TELCOR Quarles & Brady LLP	04/17/2023
22899	<b>Rush University Medical Center - West Side Walk for Wellness</b> – Repeat sponsorship with AMA name and logo.	Rush University Medical Center West Side Walk for Wellness	05/02/2023
22842	<b>National Multiple Sclerosis Society 45th Annual Ambassadors Ball</b> – Sponsorship with AMA name and logo.	National Multiple Sclerosis (MS) Society	05/05/2023
23081	<b>Essence Festival</b> – Sponsorship with In Full Health name and logo.	New Voices Foundation Essence Festival	05/23/2023
23152	<b>“Walking Backward into the Future of Chicago’s West Side” Event</b> – Sponsorship with AMA name and logo.	Medical Justice in Advocacy Fellowship Morehouse School of Medicine	05/24/2023
23115	<b>The Systems Summit on Clinical Wellbeing at Princeton University</b> - 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	<b>American Society of Bioethics and Humanities Conference</b> – Sponsorship with AMA Journal of Ethics name and logo.	American Society of Bioethics and Humanities	06/26/2023

23394	<b>National Adult and Influenza Immunization Summit</b> – 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	<b>NAACOS Fall Conference</b> – Sponsorship with AMA MAP name and logo.	National Association of Accountable Care Organizations	06/30/2023
23420	<b>SNOMED CT Expo</b> – Repeat sponsorship with AMA CPT and AMA names and logos.	Systematized Nomenclature of Medicine (SNOMED) International	07/06/2023
23656	<b>Chief Medical Officer Exchange</b> – Sponsorship with AMA name and logo.	HCPro HealthLeaders Nuance Healthcare Solutions 3M M*Modal Midmark	07/21/2023
23083	<b>ASMAC Fall Conference</b> - Sponsorship with AMA name and logo.	American Society of Medical Association Counsel	07/25/2023
23742	<b>American Conference on Physician Health</b> – Repeat sponsorship with AMA name and logo.	Stanford Medicine Mayo Clinic The Physician’s Foundation Nuance Communications	07/27/2023
23838	<b>WOEMA Conference</b> - 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	<b>GCC eHealth Workforce Development Conference</b> – Repeat sponsorship with AMA name and logo.	Gulf Cooperation Council Emirates Health Services InterSystems Malaffi CyncHealth Dell Technologies	08/07/2023
23891	<b>CFHA Integrated Care Conference</b> – Repeat sponsorship with AMA name and logo.	Collaborative Family Healthcare Association	08/07/2023
23932	<b>Genetic Health Information Network Summit</b> - Repeat sponsorship with AMA name and logo.	Concert Genetics Illumina Sarah Lawrence Genomics Institute	08/14/2023
23939	<b>HMPRG Awards Gala</b> – 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	<b>HLTH Conference</b> - Repeat sponsorship with AMA name and logo	HLTH Inc HLTH Foundation	08/17/2023

<b>24059</b>	<b>Alliance for Health Policy - Annual Dinner</b> – Repeat sponsorship 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
<b>24103</b>	<b>29th Annual Princeton Conference</b> – 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
<b>24096</b>	<b>National Press Club’s Newsmaker Series</b> – Sponsorship with AMA name and logo.	National Press Club	08/28/2023

24036	<b>APHC Conference Sponsorship</b> – 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	<b>NOAH Conference - Sponsorship</b> 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	<b>National Addiction Treatment Week - Repeat</b> 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	<b>Black Men in White Coats Youth Summit</b> - 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	<b>Women Business Leaders Annual Summit</b> - 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	<b>Hispanic Health Professional Student Scholarship Gala</b> – Sponsorship with AMA name and logo.	National Hispanic Health Foundation National Hispanic Medical Association	11/01/2023
25041	<b>HLTH Foundation Webinar</b> - Sponsorship with AMA name and logo.	HLTH Inc HLTH Foundation	11/20/2023
24941	<b>Consumer Electronics Show Digital Health Conference</b> - Sponsorship with AMA name and logo.	Consumer Technology Association American Psychological Association Connectivity Standards Alliance	11/22/2023
25305	<b>MD-Staff Educational Conference</b> - Sponsorship with AMA name and logo.	Applied Statistics & Management PreCheck The Hardenbergh Group Sterling Infosystems	12/07/2023

**EDUCATIONAL CONTENT OR GRANT**

<b><u>Project Number</u></b>	<b><u>Project Description</u></b>	<b><u>Corporations</u></b>	<b><u>Approval Date</u></b>
21752	<b>Words Matter-Making Sense of Health Equity Language Session</b> – Recording for Medscape’s CME & Education platform with AMA name and logo.	Medscape Association of American Medical Colleges	01/10/2023
22334	<b>Parkinson’s Foundation Education Series</b> - AMA EdHub hosted content with AMA name and logo.	Parkinson’s Foundation CVS Health Foundation	03/22/2023
22712	<b>AMA STEPS Forward® Plan-Do-Study-Act (PDSA) Toolkit</b> – 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	<b>Advancing AMA’s Telehealth Policy Report</b> – Co-branded research report on telehealth priorities and trends, with AMA name and logo.	Manatt Health	05/30/2023
23094	<b>Future of Health Immersion Program</b> – 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	<b>Disability Inclusion in Undergraduate and Graduate Medical Education Modules</b> - 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	<b>National Coalition for Sexual Health</b> - AMA EdHub hosted content with AMA name and logo.	National Coalition for Sexual Health Altarum Institute	09/07/2023

24576	<b>American Health Information Management Association Workshop –</b> Training on clinical documentation coding with AMA name and logo.	American Health Information Management Association	10/10/2023
24628	<b>Collaboration with Med Learning Group - AMA</b> EdHub hosted content with AMA name and logo.	Med Learning Group	10/26/2023
24905	<b>Credentialing School Sponsorship - Repeat</b> sponsorship with AMA name and logo.	Edge-U-Cate Certi-FACTS Symplr Federation of State Medical Boards	11/08/2023
24629	<b>Natural Resources Defense Council - AMA</b> EdHub hosted environmental health content with AMA name and logo.	Natural Resources Defense Council	11/10/2023

**COLLABORATIONS/AFFILIATIONS**

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
21841	<b>National Academy of Medicine’s Action Collaborative on Clinician Well-Being and Resilience -</b> 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	<p><b>Duke University Health AI Partnership (HAIP)</b> – Sponsorship of consortium and AI ethics training program with AMA name and logo.</p>	<p>Duke University Health Gordon and Betty 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</p>	01/17/2023
24871	<p><b>MAP Dashboards for Health Care Organizations</b> – AMA co-branding with healthcare organizations for MAP blood pressure dashboard project.</p>	<p>University of South Alabama CommunityHealth Corewell Health</p>	11/17/2023
21967	<p><b>American Telemedicine Association Membership</b> – Repeat sponsorship with AMA name and logo.</p>	<p>American Telemedicine Association</p>	01/26/2023
21959	<p><b>HL7 CodeX Membership</b> – Collaboration for stakeholders on CodeX project with AMA name and logo.</p>	<p>Health Level Seven International</p>	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

12/27/2023

<b>25521 Cont'd</b>	<b>Practice Transformation Survey Assessment Groups</b> – AMA co-branding with healthcare organizations for physician burnout survey project.	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 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	
<b>22118</b>	<b>HLTH Foundation</b> – Sponsorship of equity research coalition and conference with AMA name and logo.	HLTH Foundation Ipsos Group S.A.	02/27/2023
<b>22664</b>	<b>MassChallenge HealthTech</b> – 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	<p><b>“The PermanenteDocs Chat” Podcast Program -</b>          Collaboration for bi-weekly podcast program with AMA name and logo.</p>	<p>The Permanente Federation          Kaiser Permanente</p>	04/20/2023
22820	<p><b>The Collaborative for Healing and Renewal in Medicine (CHARM) -</b>          Charter committed to reducing healthcare worker burnout with AMA name and logo.</p>	<p>Alaska Native Medical Center          Allegheny Health Network          American Medical Women's Association          Brigham &amp; 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 &amp; 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</p>	05/01/2023

23018	<b>Rise to Health Coalition Collaborator Update</b> – 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	<b>National Health Equity Grand Rounds Collaborator Update</b> - Webinar series on health equity with AMA name and logo.	Social Mission Alliance	05/23/2023
23142	<b>National Association of Accountable Care Organizations Alliance Partner</b> – 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	<b>Improving Health Outcomes Research Collaboration</b> - UCSF feasibility study for wrist worn blood pressure monitoring devices.	University of California San Francisco LiveMetric	06/16/2023
23440	<b>Facility Closure Impact on Access to Maternity Care</b> – 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	<b>Connecting to Coverage Coalition</b> – Outreach program collaboration to promote Medicaid enrollment with AMA name and logo.	America’s Health Insurance Plans Thorn Run Partners	07/10/2023



23542	<b>VeriCre</b> – 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	<b>Health Equity in Organized Medicine Survey -</b> Collaboration on report summarizing survey findings with AMA name and logo.	MyWhy Agency	07/20/2023
23714	<b>Reuters Total Health –</b> 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	<b>Advancing Rural Behavioral Health Integration with Telehealth Research Program –</b> Collaborative study with AMA name and logo.	University of Hawaii John A. Burns School of Medicine The Physicians Foundation	08/18/2023

24404	<p><b>Joy in Medicine Health System Recognition Program</b>                  - Repeat AMA recognition program for outstanding healthcare organizations.</p>	<p>Baylor Scott &amp; 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</p>	09/25/2023
24250	<p><b>New MAP BP program distribution channel partner</b>                  – Collaboration to distribute MAP materials with AMA name and logo.</p>	<p>Altarum Institute</p>	10/02/2023
24306	<p><b>Joint announcement for Social Needs Assessment Coder</b> – Press release to announce new program with AMA name and logo.</p>	<p>The Gravity Project</p>	10/03/2023
24518	<p><b>Mathematica Physician Practice Information Survey</b>                  – Collaborative study on physician costs with AMA name and logo.</p>	<p>Mathematica</p>	10/05/2023
24453	<p><b>Physician Data Collaborative</b>                  – Website launch with AMA name and logo.</p>	<p>Association of American Medical Colleges                  Accreditation Council of Graduate Medical Education</p>	10/09/2023

24616	<b>MATTER Chicago</b> – Repeat sponsorship of nonprofit healthcare startup incubator with AMA name and logo.	Matter Chicago	10/10/2023
24558	<b>Prevention Strategy Collaboration with Health Care Organizations</b> – Update to program with AMA name and logo.	River Valley Family Healthcare	10/13/2023
24593	<b>Embedding Equity in Crisis Preparedness &amp; Response in Health Systems Guide</b> – 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	<b>VALID AI</b> – 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	<b>Physician Innovation Network (PIN)</b> – AMA PIN collaboration agreements with limited AMA name and logo use.	American Academy of Pain Medicine Microsoft Startup Accelerator	11/03/2023
24872	<b>Teaching Case on AMA’s Center for Health Equity</b> – Collaboration to develop a case study with AMA name.	Harvard TH Chan School of Public Health	11/06/2023
24989	<b>Common Health Coalition: Together for Public Health</b> – 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

<b>25403</b>	<b>Henry Schein Cares Foundation “Prevention is Power” Initiative –</b> 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
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**MEMBER PROGRAMS**

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
<b>21990</b>	<b>AHI Further</b> –Travel affinity program with AMA name and logo.	AHI Travel AHI Further Certares Management LLC	02/08/2023
<b>23160</b>	<b>PhysicianLoans</b> – Update to mortgage loan affinity program with AMA name and logo.	PhysicianLoans Huntington Bank	06/23/2023
<b>23155</b>	<b>AMBOSS Student &amp; Resident Member Benefit</b> – Program for test prep discounts with AMA name and logo.	AMBOSS	06/29/2023
<b>23376</b>	<b>ClassPass Member Benefit</b> – Program for discounts on fitness classes with AMA name and logo.	ClassPass	06/30/2023
<b>23161</b>	<b>Headspace Member Benefit</b> – New member incentive for discounts on meditation app with AMA name and logo.	Headspace	06/30/2023
<b>24014</b>	<b>UptoDate, Inc. Member Benefit</b> – Program for discounts on software with AMA name and logo.	UptoDate, Inc	09/07/2023

**BUSINESS ARRANGEMENTS/LICENSING PROGRAMS**

<b><u>Project Number</u></b>	<b><u>Project Description</u></b>	<b><u>Corporations</u></b>	<b><u>Approval Date</u></b>
22809	<b>Teton Data Systems -</b> Licensing agreement for AMA content to be available through online reference service.	Teton Data Systems - Stat!Ref Online	05/15/2023
22944	<b>KnowledgeWorks Global PubFactory -</b> 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	<b>LexisNexis - AMA Guides Content Integration -</b> 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	<b>JAMA Network Content -</b> 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	<b>JAMA Network Worldwide</b> – 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

# REPORT OF THE BOARD OF TRUSTEES

B of T Report 06-A-24

Subject: Redefining AMA’s Position on ACA and Health Care Reform

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

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## 1 INTRODUCTION

2  
3 At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy  
4 D-165.938, “Redefining AMA’s Position on ACA and Health Care Reform,” which calls on our  
5 American Medical Association (AMA) to “develop a policy statement clearly outlining this  
6 organization’s policies” on several specific issues related to the Affordable Care Act (ACA) as well  
7 as repealing the Sustainable Growth Rate (SGR) and the Independent Payment Advisory Board  
8 (IPAB). The adopted policy also calls for our AMA to report back at each meeting of the HOD.  
9 Board of Trustees Report 6-I-13, “Redefining AMA’s Position on ACA and Health Care Reform,”  
10 accomplished the original intent of the policy. This report serves as an update on the issues and  
11 related developments occurring since the most recent meeting of the HOD.  
12

## 13 IMPROVING THE AFFORDABLE CARE ACT

14  
15 The AMA continues to engage policymakers and advocate for meaningful, affordable health care  
16 for all Americans to improve the health of our nation. The AMA remains committed to the goal of  
17 universal coverage, which includes protecting coverage for the now more than 20 million  
18 Americans who have acquired it through the ACA. The AMA has been working to fix the current  
19 system by advancing solutions that make coverage more affordable and expanding the system’s  
20 reach to Americans who fall within its gaps. The AMA also remains committed to improving  
21 health care access so that patients receive timely, high-quality care, preventive services,  
22 medications, and other necessary treatments.  
23

24 The AMA continues to advocate for policies that would allow patients and physicians to be able to  
25 choose from a range of public and private coverage options with the goal of providing coverage to  
26 all Americans. Specifically, the AMA has been working with Congress, the Administration, and  
27 states to advance the AMA plan to cover the uninsured and improve affordability as included in the  
28 “2022 and Beyond: AMA’s Plan to Cover the Uninsured.” The COVID-19 pandemic initially led  
29 to many people losing their employer-based health insurance. This only increased the need for  
30 significant improvements to the ACA. Subsequent data indicated that the uninsured rate eventually  
31 decreased during the COVID-19 pandemic, due to the temporary ACA improvements included in  
32 the American Rescue Plan Act, continuous Medicaid enrollment, and state Medicaid expansions.  
33

34 The AMA also continues to examine the pros and cons of a broad array of approaches to achieve  
35 universal coverage as the policy debate evolves.  
36

37 *The AMA has been advocating for the following policy provisions:*

38  
39 Cover Uninsured Eligible for ACA’s Premium Tax Credits

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

#### 21 Cover Uninsured Eligible for Medicaid or Children’s Health Insurance Program

22 Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for  
23 Medicaid or the Children’s Health Insurance Program (CHIP). Reasons for this population  
24 remaining uninsured include lack of awareness of eligibility or assistance in enrollment.  
25

- 26 • The AMA has been advocating for increasing and improving Medicaid/CHIP outreach and  
27 enrollment, including auto enrollment.
- 28 • The AMA has been opposing efforts to establish Medicaid work requirements. The AMA  
29 believes that Medicaid work requirements would negatively affect access to care and lead  
30 to significant negative consequences for individuals’ health and well-being.  
31

#### 32 Make Coverage More Affordable for People Not Eligible for ACA’s Premium Tax Credits

33 Before the COVID-19 pandemic, in 2018, 5.7 million of the nonelderly uninsured were ineligible  
34 for financial assistance under the ACA, either due to their income, or because they have an offer of  
35 “affordable” employer-sponsored health insurance coverage. Without the assistance provided by  
36 ACA’s premium tax credits, this population can continue to face unaffordable premiums and  
37 remain uninsured.  
38

- 39 • The AMA advocates for eliminating the subsidy “cliff,” thereby expanding eligibility for  
40 premium tax credits beyond 400 percent FPL.
- 41 • The AMA has been advocating for the establishment of a permanent federal reinsurance  
42 program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance  
43 plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher  
44 premiums across the board in anticipation of higher-risk people enrolling in coverage.  
45 Section 1332 waivers have also been approved to provide funding for state reinsurance  
46 programs.  
47  
48  
49



- 1 • The AMA also is advocating for lowering the threshold that determines whether an  
2 employee’s premium contribution is “affordable,” allowing more employees to become  
3 eligible for premium tax credits to purchase marketplace coverage.
- 4 • The AMA strongly advocated for the Internal Revenue Service regulation that was  
5 proposed on April 7, 2022 to fix the so-called “family glitch” under the ACA, whereby  
6 families of workers remain ineligible for subsidized ACA marketplace coverage even  
7 though they face unaffordable premiums for health insurance coverage offered through  
8 employers. The Biden Administration finalized the proposed rule on October 13, 2022. The  
9 regulation resolved the family glitch by extending eligibility for ACA financial assistance  
10 to only the family members of workers who are not offered affordable job-based family  
11 coverage.

### 12 13 EXPAND MEDICAID TO COVER MORE PEOPLE

14  
15 Before the COVID-19 pandemic, in 2018, 2.3 million of the nonelderly uninsured found  
16 themselves in the coverage gap—not eligible for Medicaid, and not eligible for tax credits because  
17 they reside in states that did not expand Medicaid. Without access to Medicaid, these individuals  
18 do not have a pathway to affordable coverage.

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

20  
21 Policy adopted by the AMA HOD during the November 2021 Special Meeting seeks to assist more  
22 than two million nonelderly uninsured individuals who fall into the “coverage gap” in states that  
23 have not expanded Medicaid—those with incomes above Medicaid eligibility limits but below the  
24 FPL, which is the lower limit for premium tax credit eligibility. The new AMA policy maintains  
25 that coverage should be extended to these individuals at little or no cost, and further specifies that  
26 states that have already expanded Medicaid coverage should receive additional incentives to  
27 maintain that status going forward.

### 28 29 30 AMERICAN RESCUE PLAN OF 2021

31  
32 On March 11, 2021, President Biden signed into law the American Rescue Plan (ARPA) of 2021.  
33 This legislation included the following ACA-related provisions that:

- 34  
35 • Provided a temporary (two-year) five percent increase in the Federal Medical Assistance  
36 Percentage (FMAP) for Medicaid to states that enact the Affordable Care Act’s Medicaid  
37 expansion and covered the new enrollment period per requirements of the ACA.
- 38 • Invested nearly \$35 billion in premium subsidy increases for those who buy coverage on  
39 the ACA marketplace.
- 40 • Expanded the availability of ACA advanced premium tax credits (APTCs) to individuals  
41 whose income is above 400 percent of the FPL for 2021 and 2022.
- 42 • Gave an option for states to provide 12-month postpartum coverage under State Medicaid  
43 and CHIP.

44  
45 ARPA represents the largest coverage expansion since the ACA. Under the ACA, eligible  
46 individuals, and families with incomes between 100 and 400 percent of the FPL (between 133 and  
47 400 percent FPL in Medicaid expansion states) have been provided with refundable and  
48 advanceable premium credits that are inversely related to income to purchase coverage on health  
49 insurance exchanges. However, consistent with Policy H-165.824, “Improving Affordability in the  
50 Health Insurance Exchanges,” ARPA eliminated ACA’s subsidy “cliff” for 2021 and 2022. As a

1 result, individuals and families with incomes above 400 percent FPL (\$51,520 for an individual  
2 and \$106,000 for a family of four based on 2021 federal poverty guidelines) are eligible for  
3 premium tax credit assistance. Individuals eligible for premium tax credits include individuals who  
4 are offered an employer plan that does not have an actuarial value of at least 60 percent or if the  
5 employee share of the premium exceeds 9.83 percent of income in 2021.

6  
7 Consistent with Policy H-165.824, ARPA also increased the generosity of premium tax credits for  
8 two years, lowering the cap on the percentage of income individuals are required to pay for  
9 premiums of the benchmark (second lowest-cost silver) plan. Premiums of the second lowest-cost  
10 silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of  
11 their income. Notably, resulting from the changes, eligible individuals and families with incomes  
12 between 100 and 150 percent of the FPL (133 percent and 150 percent FPL in Medicaid expansion  
13 states) qualified for zero-premium silver plans, effective until the end of 2022.

14  
15 In addition, individuals and families with incomes between 100 and 250 percent FPL (between 133  
16 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they  
17 select a silver plan, which reduces their deductibles, out-of-pocket maximums, copayments, and  
18 other cost-sharing amounts.

#### 19 20 LEGISLATIVE EXTENSION OF ARPA PROVISIONS

21  
22 On August 16, 2022, President Biden signed into law the Inflation Reduction Act of 2022 through  
23 the highly partisan budget reconciliation process, which allows both the House and Senate to pass  
24 the bill with limits on procedural delays. Most significantly, reconciliation allows the Senate to  
25 bypass the filibuster and pass legislation with a 50-vote threshold so long as it meets a series of  
26 budgetary requirements. The Inflation Reduction Act included provisions that extended for three  
27 years to 2025 the aforementioned ACA premium subsidies authorized in ARPA.

28  
29 The Inflation Reduction Act did not include provisions to close the Medicaid “coverage gap” in the  
30 states that have not chosen to expand.

#### 31 32 ACA ENROLLMENT

33  
34 According to the U.S. Department of Health and Human Services (HHS), 21.3 million people  
35 selected an Affordable Care Act Health Insurance Marketplace plan during the 2024 Open  
36 Enrollment Period. Total plan selections include more than five million people—about a fourth—  
37 who are new to the Marketplaces and 16 million people who renewed their coverage.

#### 38 39 CONTINUOUS MEDICAID ENROLLMENT

40  
41 During the COVID-19 pandemic, the Families First Coronavirus Response Act required states to  
42 provide continuous coverage to nearly all Medicaid/CHIP enrollees as a condition of receiving a  
43 temporary federal medical assistance percentage (FMAP) increase. With disenrollments frozen,  
44 churn out of the program effectively ceased and enrollment increased nationally by 35 percent,  
45 from 70,875,069 in February 2020 to 93,876,834 in March 2023, after which the continuous  
46 enrollment requirement was lifted. Most of this growth was in the Medicaid program, which  
47 increased by 22,634,781 individuals (35.3 percent), while CHIP enrollment increased during this  
48 period by 366,984 individuals (5.4 percent). The Consolidated Appropriations Act of 2023 (CAA),  
49 which was signed into law in December 2022, established March 31, 2023, as the end date for the  
50 Medicaid continuous enrollment requirement and phased down the enhanced FMAP amount  
51 through December 2023.

1 The CAA established new requirements that states must meet to receive the phased-down FMAP  
2 increase and gave CMS authority to require states to submit monthly unwinding data, such as the  
3 number of people whose coverage was terminated, the number of those terminated based on  
4 eligibility criteria versus for procedural reasons, plus call center volume and wait times. The CAA  
5 also authorized several enforcement mechanisms including corrective action plans, financial  
6 penalties, and requiring states to temporarily pause terminations.

7  
8 The AMA continues to advocate that CMS ensure that states are maintaining Medicaid rate  
9 structures at levels that ensure sufficient physician participation, so that Medicaid patients can  
10 access appropriate, necessary care, including specialty and behavioral health services, in a timely  
11 manner and within a reasonable distance to where they live.

#### 12 13 SGR REPEAL

14  
15 The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealing and replacing  
16 the SGR was signed into law by President Obama on April 16, 2015.

17  
18 The AMA is now working on unrelated new Medicare payment reduction threats and is currently  
19 advocating for a sustainable, inflation-based, automatic positive update system for physicians.

#### 20 21 INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

22  
23 The Bipartisan Budget Act of 2018 signed into law by President Trump on February 9, 2018,  
24 included provisions repealing the Independent Payment Advisory Board (IPAB). Currently, there  
25 are not any legislative efforts in Congress to replace the IPAB.

#### 26 27 CONCLUSION

28  
29 Our AMA will remain engaged in efforts to improve the health care system through policies  
30 outlined in Policy D-165.938 and other directives of the HOD. Given that most of the ACA fixes  
31 that led to calls in 2013 for this report at every HOD meeting have been accomplished, our primary  
32 goal now related to health care reform is stabilization of the broken Medicare physician payment  
33 system, including the need for inflation-based positive annual updates and reform of budget  
34 neutrality rules.

# REPORT OF THE BOARD OF TRUSTEES

B of T Report 07-A-24

Subject: AMA Performance, Activities, and Status in 2023

Presented by: Willie Underwood III, MSc, MPH, MD, Chair

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

## 4 5 INTRODUCTION

6  
7 The AMA’s mission is to promote the art and science of medicine and the betterment of public  
8 health. As the physician organization whose reach and depth extend across all physicians, as well  
9 as policymakers, medical schools, and health care leaders, the AMA uniquely can deliver results  
10 and initiatives that enable physicians to improve the health of the nation.

### 11 *Representing physicians with a unified voice*

12  
13  
14 If the last few years have taught us anything it is that threats to the practice of medicine can come  
15 unexpectedly and from many fronts. In 2023 the AMA vigorously defended physicians and  
16 medicine in state and federal courts on a variety of issues threatening physicians and their patients.  
17 The AMA, in partnership with state medical associations and national medical specialty societies,  
18 won more than 100 state-level scope of practice cases.

19  
20 Through research, advocacy and education, the AMA continued to defend the practice of medicine  
21 against scope of practice expansions that threaten patient safety. We promoted physician-led care  
22 and helped defeat legislation across the country that would have allowed:

- 23
- 24 • Physician assistants to practice independently without physician oversight
- 25 • Pharmacists to prescribe medications
- 26 • Optometrists to perform surgery
- 27 • Scope of practice expansion for nurse practitioners and other APRNs
- 28

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

34  
35 AMA’s critical voice was represented in federal and state courts around the country on a broad  
36 range of issues, including in several cases before the U.S. Supreme Court. The AMA filed  
37 amicus briefs in: *Braidwood Management v. Becerra*, *Alliance for Hippocratic Medicine v. FDA*,  
38 and *Murthy v. Missouri*. Working with state and federal policymakers, the AMA continued to  
39 oppose legislation and laws that interfere with the practice of medicine, including in cases where  
40 physicians face criminal, civil, or administrative penalties for providing necessary care. In cases

1 ranging from surprise billing, to firearm regulations to scope of practice, the AMA has aggressively  
2 fought back to protect physicians.

3  
4 The AMA elevated the voice of physician leadership on critical issues of public health, securing  
5 more than 100 press releases, 125 billion media impressions representing nearly \$1.2 billion in  
6 estimated ad value, achieving a commanding voice among healthcare entities in the media.

7  
8 *Removing obstacles that interfere with patient care*

9  
10 Physician burnout remains an ongoing epidemic in the U.S. and the AMA is fiercely committed to  
11 understanding the challenges physicians face and to restoring their well-being and optimism. We  
12 know that reducing burnout and promoting physician well-being are inextricably linked to the  
13 delivery of high-quality patient care and health system sustainability.

14  
15 The AMA pushed forward in tackling the causes of burnout and in developing effective research  
16 and resources needed to help physicians achieve improved satisfaction and joy in their work. AMA  
17 published more than 25 peer-reviewed studies and over 2,000,000 users accessed the AMA STEPS  
18 Forward® program to prevent burnout and improve patient care and practice efficiency. AMA  
19 provided over 100 new or updated AMA STEPS Forward® resources – including toolkits,  
20 webinars, podcast episodes, and the new Wellness-Centered Leadership Playbook. AMA co-  
21 sponsored the 2023 American Conference on Physician Health with Stanford Medicine and Mayo  
22 Clinic in Palm Desert, California for over 600 attendees.

23  
24 The AMA continued to expand its work in promoting physician wellness through its Joy in  
25 Medicine™ Health System Recognition Program. This program is committed to advancing the  
26 science of physician burnout and recognizes those systems that are dedicated to organizational  
27 well-being. In 2023 the AMA recognized 72 health systems – bringing the total number of  
28 recognized organizations to 96.

29  
30 In 2023 the AMA worked with state medical associations across the country to enact prior  
31 authorization reform using AMA model legislation, data, testimony, and other resources that  
32 resulted in more than 30 states introducing legislation - and at least nine new states enacting prior  
33 authorization laws including AK, DC, IN, LA, MT, ND, NJ, RI, TN, and WA.

34  
35 The AMA successfully piloted VeriCre, a cross-industry collaboration to improve the complex  
36 credentialing process for physicians, healthcare institutions, and health plans alike. VeriCre  
37 addresses inefficiencies in credentialing by providing centralized, trusted, and authoritative data  
38 that can be used to pre-populate applications. VeriCre is designed to be integrated into vendor  
39 software solutions within healthcare organizations.

40  
41 The AMA worked to remove the barriers and end the stigma that all too frequently deters  
42 physicians from getting the mental health care they need. Our work with 15 state medical boards,  
43 health systems and credentialing bodies resulted in the removal of stigmatizing questions about  
44 mental illness from their applications.

45  
46 *Driving the future of medicine*

47  
48 The AMA achieved passage of legislation to extend Medicare telehealth coverage through 2024.  
49 The 2024 Medicare payment rule preserves key telehealth policies, ensuring Medicare patients  
50 from all areas of the country (not only rural) will continue to receive access to telehealth.

1 The AMA advanced a conceptual model for precision medical education: a system that can  
2 leverage technology and data to improve education personalization and learning efficiency across  
3 the continuum, in support of students, residents, fellows, physicians, and ultimately the  
4 needs of patients. Innovation Grants were awarded to 13 sites applying precision education  
5 approaches in medical school, residency and continuing professional development.

6  
7 The AMA ChangeMedEd® initiative and the University of Michigan developed a seven-part  
8 online learning module series introducing learners to foundational principles in artificial  
9 intelligence and machine-learning. The first of the series, Introduction to Artificial Intelligence  
10 (AI) in Health Care, launched on October 31 and was highlighted in a plenary session at the  
11 Association of American Medical Colleges Learn Serve Lead annual conference, spurring over  
12 1600 page views and 65 course completions within the month of November alone.

13  
14 AMA's influence continues through the Health Systems Science Scholars Program and the  
15 Coaching Implementation Workshop, with each program now having trained over 200 faculty  
16 members from across the US to advance these innovations in medical schools and residency  
17 programs.

18  
19 AMA Ed Hub™ continued to expand its educational offering by signing on 14 new partners in  
20 2023 - bringing the total number of partners to 50. The new partners include: American  
21 Association for Physician Leadership; American College of Occupational and Environmental  
22 Medicine; American College of Osteopathic Family Physicians; American Thoracic Surgery;  
23 Boston University; Docs with Disabilities; Endocrine Society; Mary Ann Liebert Publishers;  
24 Michigan State University; Parkinson's Foundation; Society of Critical Care Medicine; Radiology  
25 Health Equity Coalition; University of California, San Francisco, and Altarum Institute - National  
26 Coalition for Sexual Health.

27  
28 AMA Ed Hub™, in collaboration with Advocacy and Health Science & Ethics, rapidly delivered  
29 an educational offering to help physicians and clinicians meet new DEA requirements on substance  
30 use disorders and addiction. Including education from the AMA and their partners, this offering  
31 was deployed within 24 hours of the new regulation issuance and significantly contributed to  
32 increased AMA Ed Hub™ engagement.

33  
34 To better meet the needs of academic researchers, *JAMA*® optimized the publication pathway by  
35 promising to move accepted manuscripts to publication within four weeks of submission for select  
36 manuscripts of high importance. *JAMA*® also launched a new video and podcast series on "AI and  
37 Clinical Practice" to keep physicians informed on AI's promise to transform treatment, training,  
38 research and publishing. *JAMA*® hosted its first JAMA Summit™ that brought together 60 experts  
39 from across the country and world to talk about why there is a big gap between the generation of  
40 evidence and what physicians do in clinical practice including what could we do to make it better.

41  
42 The AMA's Center for Health Equity continues to strengthen physician and health system  
43 understanding and engagement around advancing equity. We launched the National Health Equity  
44 Grand Rounds, engaging almost 11,000 viewers around a variety of important topics and strategies  
45 to advance health equity and published 43 social justice education modules in the AMA Ed Hub™.

46  
47 *Leading the charge to confront public health crises*

48  
49 The AMA successfully advocated to make naloxone available over the counter and continued to  
50 advocate for responsible pricing and insurance coverage for this life-saving medication. We also  
51 successfully advocated for revisions to the Center for Disease Control's (CDC) opioid prescribing

1 guidelines that resulted in the CDC removing its dose and quantity thresholds for treating patients  
2 with pain.

3  
4 The AMA collaborated with three partners to increase access to AMA MAP™ metrics to improve  
5 the quality-of-care physicians provide to their patients with hypertension. Access to the metrics  
6 helps identify gaps, track progress, and support quality improvement efforts to reach approximately  
7 5.5 million additional patients across 683 organizations inclusive of health systems, Federally  
8 Qualified Health Centers, community health centers and medical groups.

9  
10 To help close a gap in blood pressure measurement training that exists within medical schools, the  
11 AMA awarded financial grants to eight academic institutions representing 18 total training  
12 programs for healthcare professionals allowing them to meaningfully engage in AMA's eLearning  
13 series, BP Measurement Essential: Student Edition.

14  
15 The AMA's Enterprise Social Responsibility (ESR) program has strategically integrated and  
16 aligned to the health equity strategic framework with the goal to reduce health inequities in  
17 partnership with communities. The ESR program hosted over 30 events, supported nearly 70  
18 organizations, and donated almost \$100,000 to community partners. AMA employees, representing  
19 every business unit and office location, achieved 32 percent employee volunteer participation, far  
20 exceeding the industry average of 20 percent, to build healthy, thriving, equitable communities.

#### 21 22 *AMA Task Forces*

23  
24 The task force to Preserve the Patient-Physician Relationship was formed and has convened. The  
25 Board will submit an Informational Report at the 2024 Interim Meeting that will summarize the  
26 activities of this task force that have taken place to date.

27  
28 The TRHT (Truth, Racial Healing, Transformation) task force was formed and has convened. The  
29 TRHT task force is on track to submit its recommendations to the AMA Board of Trustees by June  
30 2025.

31  
32 The Firearm Injury Prevention task force is convening and updates on its work are summarized in  
33 Board of Trustees Report 22-A-24.

34  
35 The Substance Use and Pain Care task force is convening and updates on its work are summarized  
36 in Board of Trustees Report 22-A-24.

37  
38 The Cannabis task force is convening and its work is focused on developing evidence-based  
39 education for physicians.

#### 40 41 *Membership*

42  
43 Overall, the organization's advocacy efforts and mission activities were supported by another  
44 strong year of financial performance. In 2023 the AMA experienced a 3.4% increase in overall  
45 dues-paying membership.

#### 46 47 *EVP Compensation*

48  
49 During 2023, pursuant to his employment agreement, total cash compensation paid to James L.  
50 Madara, MD, as AMA Executive Vice President was \$1,346,453 in salary and \$1,117,107 in  
51 incentive compensation, reduced by \$2,680 in pre-tax deductions. Other taxable amounts per the

1 contract are as follows: \$23,484 imputed costs for life insurance, \$24,720 imputed costs for  
2 executive life insurance, and \$4,000 paid for an executive physical, and \$3,000 paid for parking  
3 and other. An \$81,000 contribution to a deferred compensation account was also made by the  
4 AMA. This will not be taxable until vested and paid pursuant to provisions in the deferred  
5 compensation agreement.

6

7 For additional information about AMA activities and accomplishments, please see the “AMA 2023  
8 Annual Report.”



REPORT OF THE BOARD OF TRUSTEES

B of T Report 08-A-24

Subject: Annual Update on Activities and Progress in Tobacco Control: March 2023 through February 2024

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

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

4  
5 TOBACCO USE AT A GLANCE

6  
7 In the 1960s the adult smoking rate was at its highest at 42 percent.<sup>1</sup> Today that rate has been cut  
8 by more than half to an all-time low in 2022 of 11 percent. Despite this decline, tobacco use  
9 remains the leading cause of preventable disease, disability, and death in the United States.  
10 According to the Centers for Disease Control and Prevention (CDC) cigarette smoking accounts for  
11 more than 480,000 deaths every year, or about 1 in 5 deaths. More than 16 million Americans live  
12 with a smoking-related disease.<sup>2</sup>

13  
14 An annual review of tobacco use among adults, published in the May 5, 2023, Morbidity and  
15 Mortality Weekly Report (MMWR), summarizes National Health Interview Survey (NHIS) data to  
16 assess recent national estimates of commercial tobacco use among U.S. persons aged ≥18 years.  
17 NHIS is an annual, nationally representative household survey of the noninstitutionalized U.S.  
18 civilian population. Current smokers are defined as people who reported smoking at least 100  
19 cigarettes during their lifetime and who, at the time they participated in a survey about this topic,  
20 reported smoking every day or some days. This analysis found an estimated 46 million U.S. adults  
21 (18.7 percent) reported currently using any tobacco product, including cigarettes (11.5 percent), e-  
22 cigarettes (4.5 percent), cigars (3.5 percent), smokeless tobacco (2.1 percent), and pipes (including  
23 hookah) (0.9 percent). Although cigarette smoking decreased, e-cigarette use increased, from 3.7  
24 percent in 2020 to 4.5 percent in 2021, largely driven by higher prevalence in use among persons  
25 aged 18–24 years.<sup>3</sup>

26  
27 Nearly one in five adults who currently used tobacco products used two or more products, with  
28 nearly one third of these individuals (31.4 percent) reporting use of cigarettes and e-cigarettes.  
29 Dual use of tobacco products may have overlapping adverse health effects. While smoking and  
30 vaping may share similar harmful cardiovascular effects, each appears to cause some potentially  
31 damaging effects that the other does not. This suggests that dual product use may be more harmful  
32 than using either product alone.<sup>3,4</sup>

33  
34 The CDC and FDA analyzed data from the 2023 National Youth Tobacco Survey (NYTS) to assess  
35 tobacco product use patterns among U.S. middle school (grades 6–8) and high school (grades 9–  
36 12) students. This analysis was published in the November 3, 2023, MMWR.<sup>5</sup> The NYTS is a  
37 cross-sectional, school-based, self-administered web-based survey of U.S. middle and high school  
38 students. A stratified, three-stage cluster sampling procedure was used to generate a nationally  
39 representative sample of U.S. students attending private or public middle (grades 6–8) and high

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

3  
4 Current use of any use of any tobacco product by high school students declined by an estimated  
5 540,000, from 2.51 million in 2022 to 1.97 million in 2023. Declines were also reported for current  
6 e-cigarette use among high school students during that same period from 14.1 percent to 10.0  
7 percent. While these declines demonstrate the effectiveness of tobacco control legislation and  
8 regulations, there is still cause for concern. E-cigarette products were the most used tobacco  
9 product of middle and high school students with 7.7 percent reporting current e-cigarette use  
10 followed by cigarettes at 1.6 percent. Among students who had ever used an e-cigarette, 46.7  
11 percent reported current use and 89.4 percent of them used flavored products and 25.2 percent used  
12 an e-cigarette daily. Given the number of middle and high school students that use tobacco  
13 products, sustained efforts to prevent initiation of tobacco product use among young persons and  
14 strategies to help young tobacco users quit are critical to reducing U.S. youth tobacco product  
15 use.**Error! Bookmark not defined.**

### 16 17 *Sales Use of E-Cigarettes Dominated by Flavored Products*

18  
19 E-cigarette unit sales increased by 46.6 percent during January 2020–December 2022 according to  
20 a study released by the truth initiative®. The study E-cigarette Unit Sales by Product and Flavor  
21 Type, and Top-Selling Brands, United States, 2020–2022 was published in the June 23, 2023,  
22 MMWR.<sup>6</sup> From January 26, 2020, to December 25, 2022, unit shares of tobacco-flavored and  
23 mint-flavored products decreased (from 28.4 percent to 20.1 percent and from 10.1 percent to 5.9  
24 percent, respectively), whereas shares of other flavor sales increased (from 29.2 percent to 41.3  
25 percent).<sup>6</sup>

26  
27 The study authors also looked at types of e-cigarettes. Disposable e-cigarettes are the preferred  
28 delivery device for vaped tobacco. Sales of fruit- and mint-flavored disposable products saw a  
29 significant rise compared to refillable cartridge devices. During the study period, January 2020–  
30 December 2022, sales of prefilled cartridges decreased from 75.2 percent to 48.0 percent, and  
31 disposable e-cigarette sales increased from 24.7 percent to 51.8 percent. The authors attributed this  
32 to an announcement in January 2020 by the U.S. Food and Drug Administration (FDA) that the  
33 agency would prioritize enforcement against prefilled e-cigarettes in flavors other than tobacco and  
34 menthol based on the prevalence of use of these products by youth.

35  
36 In the United States, the prevalence of e-cigarette use is markedly higher among youths and young  
37 adults than it is among adults overall. In 2021, 4.5 percent of all adults aged  $\geq 18$  years (an  
38 estimated 11.1 million) and 11.0 percent of young adults aged 18–24 years (an estimated 3.1  
39 million) currently ( $\geq 1$  day during the previous 30 days) used e-cigarettes; during 2022, 14.1 percent  
40 of high school students (an estimated 2.14 million) currently used e-cigarettes. The unit share of  
41 menthol-flavored product sales remained relatively stable, while non-menthol flavor unit shares  
42 changed.<sup>6</sup>

### 43 44 EFFORTS TO ADDRESS TOBACCO CONTROL

#### 45 46 *AMA Litigation Center joins with public health groups to protect tobacco regulation*

47  
48 In the courts, the AMA has continued to be very active in supporting efforts to further regulate and  
49 limit tobacco products and electronic nicotine delivery systems (ENDS). The AMA has joined  
50 numerous amicus briefs around the country in cases involving the federal government’s efforts to  
51 regulate and remove flavored ENDS from the market, which have contributed to favorable

1 outcomes in several federal circuit courts. In addition, the AMA has supported state and local  
2 governments with friend-of-the-court briefs after their laws banning flavored tobacco products and  
3 ENDS have been challenged by the tobacco and vaping industry. Finally, the AMA continues to  
4 monitor the federal government's efforts to eliminate the manufacture and sale of tobacco products  
5 with characterizing flavors, including menthol, as the AMA was one of the named plaintiffs in a  
6 lawsuit requiring the FDA to take long-overdue action on this issue.

7  
8 The AMA Litigation Center joined amicus briefs in Oregon supporting the ability of two counties  
9 to regulate flavored tobacco products beyond the state-level restrictions. The court cases centered  
10 on whether a county ordinance banning the sale of flavored tobacco products conflicts with a state  
11 law regulating the sale of tobacco and nicotine. One of the counties received a favorable ruling, and  
12 the other matter remains pending.

13  
14 The Litigation Center also joined an amicus brief supporting the use of graphic warnings on  
15 tobacco products. The issue in *R.J. Reynolds v. FDA* is whether an FDA rule regarding graphic  
16 warnings on cigarettes is lawful. That case remains pending.

17  
18 *AMA urged the FDA to investigate violations of federal law in California*

19  
20 In December 2022 California's law prohibiting the sales of menthol cigarettes and other flavored  
21 tobacco products prevailed despite legal challenges. California became the largest state in the  
22 country banning these products and became the target for release of new products designed to  
23 circumvent the law. R.J. Reynolds announced two new brands, Camel Crisp Non-Menthol and  
24 Camel Crush Oasis Non-Menthol Capsule.

25  
26 The Tobacco Control Act, which gives the FDA authority to regulate the tobacco industry prohibits  
27 the introduction of new products that have not undergone remarket review by the FDA. The  
28 introduction and marketing of the R.J. Reynolds products and others as "substitutes" for menthol  
29 cigarettes rather than "new" products suggests that the industry believes it has found a loophole.

30  
31 In March 2023 the AMA joined by other medical, public health and community organizations  
32 urged the FDA to use its authority and begin an investigation.

33  
34 *Helping Tobacco Users Quit Act would expand and ensure cessation coverage*

35  
36 In July 2023 Congresswoman Lisa Blunt Rochester (D-Del.) and Congressman Brian Fitzpatrick  
37 (R-Penn.) introduced the Helping Tobacco Users Quit Act. This bi-partisan bill, supported by the  
38 AMA, calls for expanded comprehensive Medicaid tobacco cessation coverage in every state with  
39 no cost-sharing or access barriers for beneficiaries. The bill would also help states conduct outreach  
40 campaigns to educate providers and beneficiaries about Medicaid's coverage of cessation services.

41  
42 The bill was referred to the House Energy and Commerce Subcommittee on Health waiting for a  
43 hearing and further consideration. Medicaid enrollees smoke at twice the rate of those with private  
44 insurance, meaning that expanding cessation coverage in Medicaid would improve health outcomes  
45 while lowering government spending.<sup>7</sup>

46  
47 *American Lung Association Releases its 2024 State of Tobacco Report*

48  
49 The American Lung Association's 2024 "State of Tobacco Control" report reveals the continued  
50 impact of tobacco use, including menthol cigarettes, on individuals and families across the country,  
51 and underscores the urgent need for the White House to finalize the rules to end the sale of menthol

1 cigarettes and flavored cigars to save lives.<sup>8</sup> The report highlighted the tobacco industry and its  
2 allies' influence to successfully convince the White House to delay finalizing the menthol  
3 cigarettes and flavored cigars rules.

4 Since the 1950s, Black individuals have been successfully targeted by aggressive marketing  
5 campaigns. According to a study in the 2023 April issue of *Nicotine & Tobacco Research*, an  
6 estimated 80 percent of Black individuals in the U.S. who smoke prefer menthol cigarettes. The  
7 authors also noted that target marketing was having an impact on Hispanic adults. During the study  
8 period the use of menthol went from 34 percent in 2008 to 51 percent in 2020.<sup>9</sup>

9  
10 At the local level, Chicago, IL and Milwaukee, WI were highlighted in the report for actions taken  
11 to restrict where new tobacco retailers can locate. This legislative action takes aim at the increased  
12 concentration of tobacco product retailers in low-income neighborhoods.

---

<sup>1</sup> Giovino GA, Schooley MW, Zhu BP, Chrismon JH, Tomar SL, Peddicord JP, et al. Surveillance for Selected Tobacco-Use Behaviors - United States, 1900–1994. Centers for Disease Control and Prevention. CDC Surveillance Summaries, 1994. MMWR. 1994;43(SS-3):1–50

<sup>2</sup> [https://www.cdc.gov/tobacco/data\\_statistics/fact\\_sheets/adult\\_data/cig\\_smoking/index.htm](https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm) (accessed February 19, 2024)

<sup>3</sup> Cornelius, M. E., Loretan, C. G., Jamal, A., Davis Lynn, B. C., Mayer, M., Alcantara, I. C., & Neff, L. (2023). Tobacco product use among adults – United States, 2021. *MMWR. Morbidity and Mortality Weekly Report*, 72(18), 475–483. <https://doi.org/10.15585/mmwr.mm7218a1>

<sup>4</sup> Mohammadi, L., Han, D. D., Xu, F., Huang, A., Derakhshandeh, R., Rao, P., Whitlatch, A., Cheng, J., Keith, R. J., Hamburg, N. M., Ganz, P., Hellman, J., Schick, S. F., & Springer, M. L. (2022). Chronic e-cigarette use impairs endothelial function on the physiological and cellular levels. *Arteriosclerosis, Thrombosis, and Vascular Biology*, 2022;42(11), 1333–1350. <https://doi.org/10.1161/atvbaha.121.317749>

<sup>5</sup> Birdsey, J., Cornelius, M., Jamal, A., Park-Lee, E., Cooper, M. R., Wang, J., Sawdey, M. D., Cullen, K. A., & Neff, L. (2023). Tobacco product use among U.S. middle and high school students — National Youth Tobacco Survey, 2023. *MMWR. Morbidity and Mortality Weekly Report*, 72(44), 1173–1182. <https://doi.org/10.15585/mmwr.mm7244a1>

<sup>6</sup> Ali, F. R., Seidenberg, A. B., Crane, E., Seaman, E., Tynan, M. A., & Marynak, K. (2023). E-cigarette unit sales by product and flavor type, and top-selling brands, United States, 2020–2022. *MMWR. Morbidity and Mortality Weekly Report*, 72(25), 672–677. <https://doi.org/10.15585/mmwr.mm7225a1>

<sup>7</sup> Creamer MR, Wang TW, Babb S, Cullen KA, Day H, Willis G, Jamal A, Neff L. Tobacco product use and cessation indicators among adults—United States, 2018. [PDF – 219 KB] *MMWR Morb Mortal Wkly Rep* 2019;68:1013-1019

<sup>8</sup> <https://www.lung.org/research/sotc> (accessed February 22, 2024)

<sup>9</sup> Renee D Goodwin, Ollie Ganz, Andrea H Weinberger, Philip H Smith, Katarzyna Wyka, Cristine D Delnevo, Menthol Cigarette Use Among Adults Who Smoke Cigarettes, 2008–2020: Rapid Growth and Widening Inequities in the United States, *Nicotine & Tobacco Research*, Volume 25, Issue 4, April 2023, Pages 692–698, <https://doi.org/10.1093/ntr/ntac214>

REPORT 10 OF THE BOARD OF TRUSTEES (A-24)  
American Medical Association Health Equity Annual Report  
(Informational)

EXECUTIVE SUMMARY

**Background:** At the 2018 Annual Meeting, the House of Delegates adopted the recommendations of Policy D-180.981 directing our AMA to “develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities” and instructing the “Board to provide an annual report to the House of Delegates regarding AMA’s health equity activities and achievements.” The HOD provided additional guidance via Policy H-180.944: “Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.” HOD policy was followed by creation of the AMA Center for Health Equity (“Center”) in April 2019, 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:** The AMA has steadfastly enhanced efforts over recent years to further embed equity in our work. The Plan serves as a guide for this work. This report outlines the activities conducted by our AMA during calendar year 2023, divided into the five (5) strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3) Ensure Equity in Innovation; (4) Push Upstream; and (5) Foster Truth, Reconciliation, and Racial Healing. The diversity and inclusion strategy updates are included within the Embed Equity section.

**Conclusion:** This report captures only a fraction of the work accomplished and lessons learned in 2023. AMA staff have devoted time and resources to collaboratively advancing equity within and outside the organization. AMA continues in its quest to advance health equity and embed racial and social justice, making significant progress towards fulfilling its commitments outlined in its Strategic Plan.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-A-24

Subject: American Medical Association Health Equity Annual Report

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

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1 BACKGROUND

2

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

16

17 DISCUSSION

18

19 Our AMA has committed itself to advancing health equity, advocating for racial and social justice, and  
20 embedding equity across the organization and beyond. In 2023, the Center continued to collect enterprise-  
21 wide equity related work and track progress toward the five strategic approaches detailed in the AMA’s  
22 Plan. This report outlines the activities conducted by our AMA during calendar year 2023, divided into  
23 five strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3)  
24 Ensure Equity in Innovation; (4) Push Upstream; and (5) Foster Truth, Reconciliation, and Racial  
25 Healing. Updates on diversity and inclusion strategy updates are included within the Embed Equity  
26 section.

27

28 *Embed Equity*

29

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

35

- 36 • At the 2023 Annual and Interim House of Delegates Meetings, there were various equity-focused  
37 reports, resolutions, and educational sessions. The adopted Council on Ethical & Judicial Affairs  
38 (CEJA) Report on “[Responsibilities to Promote Equitable Care](#)” will be added to the AMA *Code*  
39 *of Medical Ethics*. Other notable reports included: [Ensuring Equity in Interview Processes for](#)

1 [Entry to Undergraduate and Graduate Medical Education](#), [Decreasing Bias in Assessments of](#)  
 2 [Medical Student Clinical Clerkship](#), [Support Removal of BMI as a Standard Measure in](#)  
 3 [Medicine](#), [Leave Policies for Medical Students, Residents, Fellows, and Physicians](#), [Financial](#)  
 4 [Burdens and Exam Fees for International Medical Graduates](#), [Challenges to Primary Source](#)  
 5 [Verification of International Medical Graduates Resulting from International Conflict](#), [Federally](#)  
 6 [Qualified Health Centers and Rural Health Care](#), and [Medicaid Unwinding Update](#). The Council  
 7 on Science and Public Health (CSAPH) and National Academy of Medicine (NAM) co-hosted an  
 8 educational session at the Interim Meeting on climate crisis and health care decarbonization.  
 9 Health Equity Open Fora were held at the Annual Meeting, highlighting the [Rise to Health](#)  
 10 [Coalition](#), [LGBTQ leadership](#), and [truth and reconciliation](#), and the Interim Meeting, focused on  
 11 the [Health Equity in Organized Medicine survey report](#) and the next Equity Strategic Plan. Each  
 12 forum had over 300 individuals in attendance.

- 13 • AMA strives toward the enterprise’s goal to raise its visibility in health equity and demonstrate its  
 14 commitment to institutional and community partners. Website traffic related to health equity  
 15 search was roughly 730,000 users. AMA published 127 news articles with health equity focus,  
 16 representing 15 percent of its total production from the news team. Membership from users  
 17 consuming health equity content increased 25 percent and referrals to health equity modules on  
 18 Ed Hub from the AMA website increased 24 percent compared to the previous year. AMA update  
 19 podcast downloads featuring health equity discussions increased 50 percent compared to the  
 20 previous year, including more than 1,200 downloads. Approximately 15,000 learners completed  
 21 AMA health equity courses for graduate and undergraduate medical education competency  
 22 education programs (GCEP and UCEP). Major 2023 health equity announcements included the  
 23 [Rise to Health Coalition](#) and the launch of the AMA’s Truth, Reconciliation, Healing and  
 24 Transformation (TRHT) taskforce initiative.
  - 25 ○ The Council of Science and Public Health (CSAPH) presented a report on equity in  
 26 precision medicine, with a four-episode podcast series in development for release in  
 27 2024.
  - 28 ○ To support reimagining the future of health equity and racial justice in medical education  
 29 and improving the diversity of the health workforce, as directed by the [Council on](#)  
 30 [Medical Education's Report 5](#) from June 2021, our AMA externally commissioned a  
 31 diverse group of subject matter experts as editors who announced a call for authors,  
 32 receiving over 150 submissions. Over 60 abstracts were published by the AMA in the  
 33 compendium *MedEd’s horizon: Just, merciful, diverse and equitable*. The final forward-  
 34 looking study with recommendations for action will be a book with approximately 18  
 35 chapters entitled *Reimagining Medical Education*, to be published by Elsevier in 2024,  
 36 and intended for medical school and health system leaders, medical educators in  
 37 undergraduate and graduate medical education (UME and GME), policy makers, change  
 38 agents, and advocates.
  - 39 ○ *AMA Journal of Ethics* published [four health equity-centered issues in 2023](#): Segregation  
 40 in Health Care, Patient-Centered Transgender Surgical Care, How We Over Rely on BMI  
 41 and Palliative Psychiatry, with the first issue including an article led by AMA staff:  
 42 [Training to Build Antiracist, Equitable Health Care Systems](#).
  - 43 ○ To help embed equity within public health, the AMA published, in collaboration with the  
 44 U.S. Centers for Disease Control and Prevention’s (CDC) Project Firstline, 12 episodes  
 45 of the [Stories of Care](#) podcast about health care equity and infection control, including:  
 46 [Race, Research, and Health Care Associated Infections](#), [Fighting Ableism: What Do You](#)  
 47 [Need?](#), and [Fighting Stigmas Associated With Infectious Diseases](#). Through October  
 48 2023, the Stories of Care podcast had a total of 1,311 downloads and 701 continuing  
 49 medical education (CME) completions.
  - 50 ○ The AMA continues to partner with the CDC and the Ad Council to encourage the  
 51 public, with an emphasis on Black and Latinx/Hispanic audiences, to get vaccinated

1 against influenza (flu). The donated media value for the most recent flu season was about  
2 \$4.8 million. The public service announcement (as of October 2023) reached 53 percent  
3 among Black and 48 percent among Hispanic respondents. We held two media tours in  
4 2023, both in English and Spanish, with spokespeople from AMA and CDC securing  
5 nearly 400 placements across TV, radio, and digital.

- 6 ○ The AMA published playbooks and other educational resources for physicians, practices,  
7 physician provider organizations, and health systems: as part of STEPS Forward,  
8 [Wellness-Centered Leadership](#) with a chapter on Racial and Health Equity; and with  
9 America's Health Insurance Plans (AHIP) and National Association of Accountable Care  
10 Organizations [The Future of Sustainable Value-Based Payment: Voluntary Best Practices](#)  
11 [to Advance Data Sharing](#), incorporating the promotion of health equity as a key cross-  
12 cutting issue (particularly related to health-related social needs) and establishing a  
13 specific “best practice category” focused on health equity (“Improve Data Collection and  
14 Use to Advance Health Equity”). Additionally, AMA STEPS Forward published a  
15 toolkit, [Collective Trauma: Respond Effectively as an Organization](#), and four podcasts  
16 focused on social determinants of health and racial and health equity.
- 17 ○ AMA STEPS Forward® hosted the first-ever free in-person Saving Time Boot Camp,  
18 intended for Federally Qualified Health Centers (FQHC) staff, offering evidence-based  
19 time management strategies to provide quality patient care.
- 20 ○ Private Practice Simple Solutions (PPSS) learning collaboratives were created in support  
21 of practices in communities that may lack financial resources to engage with consultants  
22 or other external partners.
- 23 ○ The AMA produced six Prioritizing Equity episodes, including: [Examining Physician](#)  
24 [Gender Inequity in Medicine](#), [The SCOTUS Affirmative Action ruling: The Cost to the](#)  
25 [Physician Workforce and Historically Marginalized Communities](#), and [Advocating for](#)  
26 [Change in Native Health Policy](#).

- 27
- 28 ● The AMA provided a detailed internal report to all staff on the first year of cross-enterprise and  
29 Business Unit (BU)-specific Equity Action Plans, including some 200 goals across BUs.  
30 Leadership approved moving forward with an Embedding Equity dashboard in 2024 starting with  
31 the 2020 Employee Equity and Engagement Survey data, moving forward with the next  
32 Employee Equity and Engagement Survey (slated to deploy in 2025), and implementing in 2024  
33 the first enterprise-wide equity goals to be included in every BU’s goals, focused on workforce  
34 and learning.
- 35 ● The annual update to the Current Procedural Terminology (CPT) code set for 2024 included  
36 Spanish language consumer-friendly descriptors for the first time, which will help CPT users  
37 better engage and assist the Latinx community.
- 38 ● For more than 50 years of the CPT Professional book being published and in circulation, every  
39 medical illustration that showed skin tone depicted a white person. In 2023, to address the past  
40 exclusion of images that represent the full diversity and identities of the people in our society, the  
41 book updated 19 illustrations, including changes to skin tone, facial features, hair, and sex. The  
42 2024 edition updated and diversified 11 illustrations as well as reworked and made additional  
43 improvements to three illustrations from 2023. A large diverse group of internal and external  
44 reviewers provided feedback prior to publication. There is a three-year plan to update 75-100  
45 more illustrations to depict authentic and diverse illustrations in the over 200,000 copies sold  
46 each year.

47

48 The AMA’s employee life cycle and internal diversity, equity, and inclusion (DEI) framework help to  
49 operationalize DEI initiatives across the enterprise. Within the embedding equity strategic approach,  
50 updates on the AMA’s diversity and inclusion strategy included a number of efforts and initiatives:  
51



- 1 • Across AMA, hundreds of staff in 2023 engaged in training and educational opportunities with  
2 over 60 percent reporting an increase in knowledge, attitudes, skills, or behaviors. Training  
3 included the two-day Racial Equity Institute (REI) Phase 1, the Interaction Institute for Social  
4 Change (IISC) Facilitative Leadership for Social Change, the Equity & Results Antiracist  
5 Results-Based Accountability series, four new skills-based inclusion modules designed,  
6 developed, piloted, implemented and evaluated, and Business Unit-specific offerings led by their  
7 Health Equity Action Team.
- 8 • Individual Business Units have, with the leadership of their respective Health Equity Action  
9 Teams, pursued a variety of strategies to operationalize equity: had every team member commit  
10 to one of four committees and one goal from their Equity Action Plan, meeting at least monthly;  
11 designed and implemented internal monthly reporting to support transparency, dialogue, and  
12 decision-making; launched an internal monthly digest to educate colleagues; defined and shared a  
13 safe-space framework, rules, and expectations for town hall meetings and issues that arise;  
14 implemented community agreements across meetings and incorporated them into a project  
15 management playbook (with 79% finding the brave space community agreement beneficial);  
16 piloted Racial Healing Circles as a tool for team building across cultural divides; weaved meeting  
17 with the Health Equity Action Team about their Equity Action Plan and its progress into the new  
18 hire onboarding process; helped clients to consider embedding equity principles throughout  
19 projects (e.g., what language is being used, whether the team is diverse, is there a consideration of  
20 the project's impact on minoritized or marginalized communities, and other essential questions);  
21 and developed a process to ensure research proposals are evaluated for design bias and equity  
22 impact.
- 23 • The AMA is analyzing existing IT documentation in shared repositories for identification and  
24 removal of racially demeaning terms.
- 25 • Starting in 2023, several JAMA Network journals revamped and expanded their editorial  
26 fellowship programs to be part-time and fully remote to increase accessibility and inclusivity. The  
27 JAMA Network Equity Action Team (JNEAT) established guidelines for staff at every level to  
28 understand how to meet individual goals for improving Diversity, Equity, Inclusion, and  
29 Belonging – from supporting hiring managers in seeking a diverse candidate base for job  
30 openings to providing educational opportunities for staff. JAMA Network DEI editors continued  
31 quarterly discussions within their individual journals. The team will be publishing results of an  
32 inter-departmental survey of editors and editorial boards that highlight staff demographics,  
33 including self-identified gender, race, and ethnicity.
- 34 • The AMA made its offices more equitable, installing privacy strips in the restrooms, stocking  
35 menstrual supplies in all restrooms, facilitating hybrid meetings with necessary accommodations,  
36 and installing or ordering sit/stand desks and other ergonomic office equipment. The organization  
37 continues to work towards ensuring AMA offices are accessible for differently abled individuals.  
38

### 39 *Build Alliances and Share Power*

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

- 45 • AMA's sponsorship plan reflected outreach to diverse audiences, including The National  
46 LGBTQ+ Journalists Association (NLGJA) and Asian American Journalists Association (AAJA)  
47 Journalists conferences.  
48

- 1 • Three new health equity-oriented content partners were signed to AMA’s Ed Hub: Docs with  
2 Disabilities, Radiology Health Equity Coalition (RHEC), and UCSF Center for Climate Health  
3 Equity. The AMA collaborated with HealthBegins to launch six modules of [Upstream Training  
4 and Education](#).
- 5 • To further leverage existing resources and partnerships, AMA participated in four meetings with  
6 the Association of American Medical Colleges (AAMC) and the Accreditation Council for  
7 Graduation Medical Education (ACGME) about diversifying the physician workforce; attended  
8 three ACGME Diversity Officers Forums; delivered two webinars (Removing barriers and  
9 facilitating access: Supporting trainees with disabilities across the medical education continuum  
10 and Enhancing Diversity Among Academic Physicians: Recruitment, Retention and  
11 Advancement), two presentations to Academic Physicians Section on equity, diversity and  
12 belonging focused on medical education and minoritized physician burnout and wellbeing, and  
13 three presentations on the implications of the Supreme Court (SCOTUS) decision of Students for  
14 Fair Admissions v. Harvard University and the University of North Carolina at Chapel Hill; and  
15 completed a review of configurative mapping on diversity in medical education.
- 16 • Continuing its work around physician workforce data, the AMA is collaborating with the AAMC  
17 and the ACGME to establish a common understanding for the categorization, reporting, and  
18 sharing of sociodemographic data, beginning with race and ethnicity. This collaborative  
19 completed a study and is finalizing a guide on the addition of the Middle Eastern North African  
20 (MENA) category, identifying best practices in aggregation and reporting. Categorization has  
21 been provided by the AMA to the American Board of Medical Specialties, Federation of State  
22 Medical Boards, Council for Affordable Quality Healthcare, Massachusetts Medical Society, and  
23 Workgroup for Electronic Data Interchange health equity work group. MedBiquitous, a standards  
24 development organization in the academic medicine space, has expressed interest in adopting the  
25 categorization being developed by the collaborative in lieu of creating their own.
- 26 • The AMA, alongside AHIP, the Alliance of Community Health Plans, the American Hospital  
27 Association, and Kaiser Permanente, launched the Common Health Coalition: Together for  
28 Public Health. The coalition is focused on translating the hard-won lessons and successes of the  
29 COVID-19 pandemic response into actionable strategies that will strengthen the partnership  
30 between our health care and public health systems. In 2024, the coalition will publish  
31 recommendations informed by technical advisory groups of subject matter experts and an  
32 advisory council of public health leaders, focused on four initial priority areas: spearheading  
33 greater coordination between the public health and health care systems; building shared, well-  
34 maintained emergency preparedness plans; establishing national standards for health care data  
35 that help identify health disparities; and modernizing infectious disease detection.
- 36 • AMA continues to work in partnership with the March of Dimes (MOD) and has contracted with  
37 MOD and Sinai Urban Health Institute to identify the impact of facility closures and loss of  
38 services on the South and West side of Chicago, with the goal of producing a final report in 2024.  
39 AMA aims to continue its engagement with and participation in the MOD workgroups  
40 (Dismantle Racism, Increasing Access to Care, and Engage Communities).
- 41 • AMA staff continue to volunteer locally and build meaningful relationships with community  
42 organizations. The Enterprise Social Responsibility (ESR) team has aligned with the health equity  
43 strategic framework by valuing and uplifting the variety and diversity of work and careers that  
44 address social determinants of health and contributes to wellness. ESR piloted a co-design  
45 process with three community partners to develop a signature service model to address emerging  
46 community needs while aligning with AMA’s mission and equity goals. ESR identified and  
47 hosted about 35 community engagement opportunities to build healthy, thriving, equitable  
48 communities, including My Block, My Hood, My City; Gardeneers; and the Erie House.
- 49 • The second cohort of the Medical Justice in Advocacy Fellowship, an educational initiative in  
50 collaboration with Morehouse School of Medicine’s Satcher Health Leadership Institute,

1 culminated at the Interim meeting of the House of Delegates, where 11 physician leaders were  
2 celebrated and presented their health equity project concepts.

- 3 • The AMA launched its inaugural Summer Health Law Internship, an eight-week paid summer  
4 internship program for a third year or master's law student to learn more about health equity and  
5 health law; continued working with The Urban Alliance by hosting a summer internship program  
6 that exposes Chicago students to medical publication to provide career exposure; hired a summer  
7 intern from Chicago Public Schools in Finance; and partnered with University of Chicago's Youth  
8 Internship Program, hosting an onsite a panel discussion with 23 IT-interested high school  
9 students, and are exploring further IT mentoring opportunities.
- 10 • The AMA completed a total of 32 burnout assessments with FQHCs and/or community health  
11 centers, all organizations serving patients from predominantly historically marginalized  
12 communities. Twenty of the 32 assessments were conducted for the organizations in the Arizona  
13 Alliance, a consortium of FQHCs, as well as several virtual workshops and reporting sessions to  
14 provide insight into interventions to reduce medical staff burnout. Several participating FQHCs  
15 were recognized through the AMA's [Joy in Medicine™ Health System Recognition Program](#).
- 16 • Minority and/or woman owned businesses were identified and recommended for several projects,  
17 including one with an estimated value in excess of \$250,000. Additionally, three West Side  
18 United (WSU) vendors were recommended for requests for proposals with more than \$700,000  
19 spent with Local Vendors reported in monthly WSU Anchor Partner meetings. The AMA  
20 released a DEI survey to professional services vendors with material levels of spending in 2023 to  
21 collect information about the vendors and their policies regarding marginalized populations and  
22 DEI.
- 23 • The AMA set a five-year goal to scale and improve programs to five million patients diagnosed  
24 with hypertension (HTN) to achieve a 10 mm Hg drop in systolic blood pressure (SBP) or reach  
25 BP goal, and one million patients identifying as Black, Latina/e/o/x/Hispanic, Asian, Indigenous,  
26 and other historically marginalized groups. As of the end of 2023, approximately 71,723 patients  
27 had been impacted, with 51percent from historically marginalized populations. This number  
28 includes patients from two large health care organizations located in the West Side of Chicago.  
29 Additionally, the AMA initiated projects to embed and advance equity within its AMA MAP  
30 HTN™ program to better understand the impact of the program on historically marginalized  
31 populations and identify opportunities to reduce inequities.

### 32 Push Upstream

33  
34  
35 Pushing upstream requires looking beyond cultural, behavioral, or genetic reasons to understand structural  
36 and social drivers of health and inequities, dismantle systems of oppression, and build health equity into  
37 health care and broader society. The following are some of the relevant accomplishments during 2023:  
38

- 39 • AMA continues to embed equity in its state and federal advocacy work and continues to elevate  
40 this and other equity-related work accomplished among AMA members and Federation Societies.  
41 Equity-related policy priorities can be seen throughout the AMA's engagement with Congress,  
42 the Administration, state legislatures, and other policymakers, in the form of advocacy letters,  
43 presentations and testimony to state legislatures, national and medical organizations, and  
44 countless additional opportunities that engaged organized medicine and policymakers. In 2023,  
45 the AMA continued to actively voice support for:
  - 46 ○ International medical graduates (IMGs);
  - 47 ○ Deferred Action for Childhood Arrivals (DACA) recipients;
  - 48 ○ Migration and refugee population health and safety;
  - 49 ○ Nutrition programs expansion and culturally respectful dietary guidelines;
  - 50 ○ Medicaid coverage expansion;

- 1           ○ Medicaid and Children’s Health Insurance Program (CHIP) coverage extension;
- 2           ○ Maternal and child health programs;
- 3           ○ Protecting reproductive health;
- 4           ○ Advancing data privacy principles and protecting the abuse/misuse of sensitive health
- 5           data;
- 6           ○ [Enhanced revisions to the federal race and ethnicity data standards](#);
- 7           ○ Mental health and substance use disorder parity laws;
- 8           ○ Removing racial and gender inequities for treatment of substance use disorders;
- 9           ○ Protections for physicians who seek care for wellness and burnout;
- 10          ○ Evidence-based gender affirming care;
- 11          ○ Prohibition of the so-called conversion therapy;
- 12          ○ Fair student loan efforts;
- 13          ○ Increased funding for graduate medical education;
- 14          ○ Elimination of harmful race-based clinical algorithms;
- 15          ○ Telehealth flexibilities in Medicare;
- 16          ○ Reducing the prior authorization burden on patients; and
- 17          ○ Addressing quality and administrative barriers in Medicare Advantage and other
- 18          insurance plans.
- 19          • In late May, in partnership with Institute for Healthcare Improvement (IHI), and in collaboration
- 20          with Race Forward, HealthBegins, Groundwater Institute, and a variety of other organizations,
- 21          the AMA [formally announced the launch](#) of Rise to Health: A National Coalition for Equity in
- 22          Health Care. The goal of the Rise to Health Coalition is to bring together individuals and
- 23          organizations across five key audiences (pillars) including: individual practitioners, health care
- 24          organizations, professional societies, payers, and pharma, research, biotech organizations, to
- 25          advance health equity by identifying shared solutions, common frameworks, and best practices
- 26          for spread and scale.
- 27          • The AMA continues to publish highly engaging health equity content on the AMA Ed Hub site
- 28          with 176 activities published in 2023. Uptake of equity content in 2023 far exceeded 2022, with
- 29          213,982 engagements (compared to 161,189) and 53,117 course completions (compared to
- 30          32,453). Four [National Health Equity Grand Rounds](#) sessions were held, which brought 10,189
- 31          registrations (8,254 new registrants) to the Ed Hub site: [The History of Racism in US Health](#)
- 32          [Care](#); [Follow the Money](#); [Breaking Down the Ivory Tower](#); and [Creating Accountability Through](#)
- 33          [Data](#). Each session was designed to maximize accessibility for viewers.
- 34          • The AMA is a founding member of The Gravity Project, a Health Level 7 Fast Healthcare
- 35          Interoperability Resources Accelerator focusing on social determinants of health (SDOH) data
- 36          interoperability. The AMA contributes funding and staff time, for leadership and co-development
- 37          of the SDOH terminology and data exchange standards. The newly released White House “[US](#)
- 38          [Playbook to Address Social Determinants of Health](#)” for federal initiatives recognized the Gravity
- 39          Project throughout the document. The AMA provided education to physicians on the utility of
- 40          CPT codes to document and provide services based upon identified SDOH.

41  
42 *Ensure Equity in Innovation*

43  
44 The AMA is committed to ensuring equitable health innovation by embedding equity in innovation,  
45 centering historically marginalized and minoritized people and communities in development and  
46 investment, and collaborating across sectors. The following are some of the relevant accomplishments  
47 during 2023:

- 48
- 49          • The AMA continues to strive toward the adoption, optimization, and sustainability of responsible,
- 50          impact and equitable digitally enabled innovations. This includes highlighting organizations that

1 are championing and implementing health equity on the Physician Innovation Network (PIN) and  
2 providing a place for the Principles of Equitable Innovation to engage in important conversations  
3 through PIN. The AMA connected stakeholders and fostered collaboration to improve the  
4 development, evidence base, and quality of digital health solutions.

- 5 • The AMA's In Full Health initiative, in collaboration with The New Voices Foundation, provided  
6 five microgrants to Black healthcare/health tech entrepreneurs to attend The New Voices  
7 Foundation Health Innovator Hub at ESSENCE Festival 2023. The Black health innovators  
8 created solutions through tech, community partnerships, and medicine – building businesses that  
9 meet critical needs in the Black community and advance health equity. The healthcare/health tech  
10 entrepreneurs exhibit at the Innovator Hub at the ESSENCE Festival, which is visited by over  
11 500,000 people each year.
- 12 • At the May CPT Editorial Panel Meeting, they approved adding eight questions to the CPT Code  
13 Change Application to help the Panel make informed decisions about AI CPT applications and  
14 apply the AI Taxonomy (Appendix S in the CPT Code Set) consistently. One question asks the  
15 applicant to explain how bias factors into the algorithm data.

### 16 17 Foster Truth, Racial Healing, Reconciliation, and Transformation

18  
19 The AMA recognizes the importance of acknowledging and rectifying past injustices in advancing health  
20 equity for the health and well-being of both physicians and patients. Truth, racial healing, reconciliation,  
21 and transformation is a process and an outcome, documenting past harms, amplifying and integrating  
22 narratives previously made invisible, and creating collaborative spaces, pathways, and plans. The  
23 following are some of the relevant accomplishments during 2023:

- 24  
25 • The AMA launched the Truth, Reconciliation, Healing and Transformation (TRHT) Taskforce,  
26 comprised of 19 people: AMA Board of Trustees liaisons, members of the AMA House of  
27 Delegates, physicians from historically marginalized communities, and external subject-matter  
28 experts from key fields such as medical history and education, policy, ethics, philanthropy, and  
29 economics. Facilitated dialogues took place in New Mexico and on Chicago's West Side ([at the](#)  
30 [Hatchery](#)), with educational sessions at the 2023 [Annual](#) and Interim Meetings of House of  
31 Delegates (HOD). The Hatchery and HOD sessions are being made available on Ed Hub in 2024.

### 32 33 Challenges and Opportunities

34  
35 Commonly noted challenges to advancing health equity, in order of most frequently cited to least,  
36 include: 1) limited staff time and capacity for content engagement and external collaborations, 2)  
37 competing operational and scheduling priorities, 3) budgetary limitations for sustainability and scaling up,  
38 4) lack of guidance and standardization across enterprise, and 5) uncertainty around implementation and  
39 evaluation of processes and projects. Additional progress has been made this year to promote diversity  
40 within the AMA, and continuation and scaling of these efforts are vital to advancement of equitable work  
41 and workplace.

42  
43 Many of AMA's BUs reported exploring initiatives to foster space and engagement around diversity,  
44 inclusivity, transparency, and accountability among their unit. Other BUs reported relying on their Health  
45 Equity Action Team ("HEAT") staff leaders to lead and advance their respective unit's equity efforts, and  
46 while these leaders' expertise have made great strides toward spearheading initiatives and setting  
47 structures for equitable work, staff are faced with limited time, capacity, resources on top of competing  
48 priorities with tight deadlines. Some BUs have identified these issues, and a few have created  
49 opportunities for cross unit engagements to foster collaboration and reignite responsibility toward AMA's

1 equity goals. As an organization, there is a keen interest in solidifying an enterprise-wide equitable  
2 workplace foundation and investing efforts toward strategic operationalizing of AMA's equity goals.

3  
4 CONCLUSION

5  
6 The highlighted accomplishments in this report capture only a fraction of the work accomplished and  
7 lessons learned within 2023. AMA staff have devoted countless hours to not only learning how they can  
8 work together to advance health equity but also to applying what they have learned within and outside the  
9 organization. AMA continues to push forward in its quest to advance health equity and embed racial and  
10 social justice, making significant progress towards fulfilling its commitments outlined in its 2021-2023  
11 Strategic Plan.

# REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-A-24

Subject: AMA Efforts on Medicare Payment Reform

Presented by: Willie Underwood, III, MD, MSc, MPH, MD, Chair

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1 BACKGROUND

2

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

13

14 AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

15

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

22

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

25

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

32

33 At the heart of the AMA’s unwavering commitment to reforming the Medicare physician payment  
34 system lie four central pillars that underscore our strategic approach: legislative advocacy,  
35 regulatory advocacy, federation engagement, and grassroots, media, and outreach initiatives.  
36 Grounded in principles endorsed by a unified medical community, our legislative efforts drive the  
37 advancement of policies that foster payment stability and promote value-based care. We actively  
38 champion reform through regulatory channels, tirelessly engaging with crucial agencies such as the  
39 Centers for Medicare & Medicaid Services (CMS) and the White House to address impending  
40 challenges and ensure fair payment policies. Our federation engagement fosters unity and consensus



1 within the broader medical community, pooling resources and strategies to amplify our collective  
2 voice. Lastly, our continued grassroots, media, and outreach efforts bridge the gap between  
3 policymakers and the public, ensuring our mission is well-understood and supported from all  
4 quarters. Together, these pillars fortify our endeavors to achieve a more rational Medicare physician  
5 payment system that truly benefits all.

6  
7 *Legislative Advocacy*

8  
9 As a result of the continued advocacy efforts of the AMA and larger physician community and  
10 direct engagement with Congress, a collection of influential Dear Colleague letters and  
11 commonsense legislative reforms have been introduced that build upon “Characteristics of a  
12 Rational Medicare Physician Payment System” including:

13  
14 H.R. 2474, the Strengthening Medicare for Patients and Providers Act, introduced on April 14, 2023  
15 by Reps. Raul Ruiz, MD (D-Calif.), Larry Bucshon, MD (R-Ind.), Ami Bera, MD (D-Calif.) and  
16 Mariannette Miller-Meeke, MD (R-Iowa), would automatically update the Medicare physician  
17 payment schedule each year by Medicare’s annual estimate of practice cost inflation, the MEI. H.R.  
18 2474 currently has 126 bipartisan cosponsors.

19  
20 On July 28, 2023, a bipartisan group of 101 U.S. House of Representatives members sent a letter to  
21 House leadership on the need to prioritize Medicare physician payment reform, following extensive  
22 grassroots support from the AMA and members of the Federation.

23  
24 H.R. 6371, the Provider Reimbursement Stability Act, introduced on November 13, 2023 by Rep.  
25 Greg Murphy, MD (R-N.C.) and 14 original cosponsors, would reform the Medicare Physician Fee  
26 Schedule (MPFS) budget neutrality policies by: (1) requiring CMS to reconcile inaccurate  
27 utilization projections based on actual claims and prospectively revise the conversion factor (CF)  
28 accordingly; (2) raise the threshold that triggers a budget neutrality adjustment from \$20 million to  
29 \$53 million and increase it every five years by the cumulative increase in the MEI; (3) require the  
30 direct inputs for practice expense relative value unit (i.e., clinical wages, prices of medical supplies  
31 and prices of equipment) to be reviewed concurrently and no less often than every five years; and  
32 (4) require CMS to limit positive or negative budget neutrality adjustments to the CF to 2.5 percent  
33 each year. In November of 2023, the House Committee on Energy and Commerce advanced select  
34 provisions of H.R. 6371 to reform fee schedule budget neutrality policies.

35  
36 H.R. 5013/S. 3503, the Value in Health Care (VALUE) Act, introduced on July 28, 2023 by Reps.  
37 Darin LaHood (R-Ill.) and Suzan DelBene (D-Wash.) in the House and Senators Whitehouse (D-  
38 R.I.) and Barrasso (R-Wyo.) in the Senate on December 13, 2023, would extend the 5 percent APM  
39 bonus and maintain the 50 percent revenue threshold for two years.

40  
41 In November of 2023, the Senate Committee on Finance and the House Committee on Energy and  
42 Commerce advanced legislation to offset a portion (1.25 percent) of the 2024 CF cuts as well as to  
43 partially extend the APM bonus and maintain the current revenue threshold required for the  
44 bonuses. During these markups, members of both committees discussed the need for Medicare  
45 payment reform at length and secured pledges from the chairs to address the issue in earnest in  
46 2024.

47  
48 H.R. 6683, the Preserving Seniors’ Access to Physicians Act, introduced on December 8, 2023 by  
49 Reps. Greg Murphy, MD (R-N.C.), Danny Davis (D-Ill.), Brad Wenstrup (R-Ohio), Michael  
50 Burgess, MD (R-Texas), Jimmy Panetta (D-Calif.) and Larry Bucshon, MD (R-Ind.), would provide



1 full, short-term relief from the 3.37 percent cut imposed in 2024 due to the budget neutrality policies  
2 medicine is seeking to reform.

3  
4 Nearly 200 bipartisan members of Congress cosigned a Dec. 13 [letter](#) led by Representatives  
5 Mariannette Miller-Meeks, MD (R-IA), Ami Bera, MD (D-CA), Larry Bucshon, MD (R-IN) and  
6 Kim Schrier, MD (D-WA) urging House and Senate leadership to expeditiously pass legislation to  
7 address looming 2024 Medicare payment cuts. Absent congressional intervention, Medicare  
8 physician payments will be reduced by 3.37 percent on Jan. 1, 2024, due to budget neutrality  
9 requirements within the Calendar Year 2024 MPFS Final Rule.

10  
11 On Feb. 9, Senators Cortez Masto (D-NV), Blackburn (R-TN), Thune (R-SD), Barrasso (R-WY),  
12 Stabenow (D-MI) and Warner (D-VA) announced the formation of a bipartisan Medicare payment  
13 reform working group. The primary goal of this working group is to explore the current problems  
14 with the MPFS, propose long-term solutions and make the necessary updates to the Medicare  
15 Access and Chip Reauthorization Act (MACRA), which sets physician payment policies in the  
16 Medicare program. The AMA will serve as a resource to the Senate working group.

17  
18 On February 23, 2024, Senators John Boozman (R-AR) and Peter Welch (D-VT) along with 30  
19 Senators colleagues sent a Dear Colleague [letter](#) calling on Senate leadership to advance a  
20 legislative solution to create stability in the Medicare program by addressing the 2024 cut to  
21 Medicare payments and ensure that physicians and clinicians have the necessary financial support to  
22 care for the nation's seniors.

23  
24 The Consolidated Appropriations Act, 2024, H.R. 4366, which passed the House of Representatives  
25 and the Senate and was signed into law by President Biden on March 8, included provisions  
26 reducing by about half —1.68 percent —of the 3.37 percent across-the-board Medicare physician  
27 pay cut that took effect on January 1. The new pay rate took effect on March 9.

28  
29 The legislation also included an extension of incentive payments for participation in eligible  
30 alternative payment models at a reduced rate of 1.88 percent and maintained the threshold  
31 requirements to qualify for such payments.

32  
33 The AMA issued a statement expressing extreme disappointment that about half of the 2024  
34 Medicare physician payment cuts required by the Medicare Fee Schedule will be allowed to  
35 continue. The AMA conveyed that failure to reverse these cuts will impact access to high quality  
36 care and physicians will find it more difficult to accept new Medicare patients.

37  
38 The AMA will continue to work with Congress and the administration to build bipartisan support in  
39 Congress for a proposal that will put an end to the annual cycle of Medicare cuts that threaten  
40 seniors' access to care. Bipartisan support for the aforementioned legislative proposals continues to  
41 grow among rank-and-file Members of Congress. However, the need for further advocacy remains  
42 to push the relevant Committees and Congressional leadership to make Medicare physician payment  
43 reform a top priority.

44  
45 The AMA is also in the process of finalizing legislative language that would: (1) simplify MIPS  
46 reporting and improve its clinical relevance; (2) reduce the potential severity of penalties (currently  
47 as much as -nine percent) for those scoring poorly under MIPS; (3) provide support to smaller  
48 practices that tend to score lower under the program; and (4) provide timely and meaningful  
49 performance feedback to physicians and expand the use of clinical data registries.

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

- 3
- 4 • 1/2/23 - signed on a physician/allied health professions [letter](#) to Congressional committees
- 5 requesting MACRA oversight hearings;
- 6 • 2/13/23 - signed on a coalition [letter](#) to committees on value-based care;
- 7 • 3/15/23 - a sign on [letter](#) developed by the AMA was sent to Congress regarding the
- 8 Medicare Payment Advisory Committee (MedPAC) recommendation for an inflation-based
- 9 update;
- 10 • 3/20/23 - an AMA [statement](#) was filed for the Senate Health, Education, Labor and Pensions
- 11 Committee’s health care workforce hearing, highlighting the impact of declining Medicare
- 12 payments on the physician workforce;
- 13 • 4/19/23 - a sign on [letter](#) developed by the AMA was sent to the House expressing support
- 14 for H.R. 2474;
- 15 • 5/3/23 - signed on a physician/allied health professions [letter](#) to Congress in support of H.R.
- 16 2474;
- 17 • 6/21/23 - the AMA submitted a [letter](#) for the record for a hearing by the House Energy &
- 18 Commerce Oversight & Investigations Subcommittee on MACRA;
- 19 • 10/5/23 - the AMA [responded](#) to the Ways & Means Committee’s Request for Information
- 20 on ways to improve health care in rural and underserved areas;
- 21 • 10/19/23 - the AMA submitted a [statement](#) for the Record to the U.S. House of
- 22 Representatives Committee on Energy and Commerce Subcommittee on Health as part of
- 23 the hearing entitled “What’s the Prognosis? Examining Medicare Proposals to Improve
- 24 Patient Access to Care & Minimize Red Tape for Doctors.”
- 25 • 12/11/23 - the AMA [wrote](#) in strong support of H.R. 6683, the “Preserving Seniors’ Access
- 26 to Physicians Act,” bipartisan legislation that blocks another round of damaging Medicare
- 27 payment cuts;
- 28 • 1/17/24 - the AMA organized national medical organizations and state medical societies to
- 29 write a [letter](#) strongly urging Congress to quickly pass legislation to reverse the 3.37 percent
- 30 Medicare physician payment cuts that took effect on January 1, 2024.

### 31 32 *Regulatory Advocacy*

33  
34 In anticipation of a new round of budget neutrality adjustments expected in 2024 due to  
35 implementation of the G2211 code for complex office visits, the AMA had a multitude of meetings  
36 with officials at CMS, the Department of Health and Human Services (HHS), and the White House  
37 to discuss options for reducing the severity of the adjustment—and to argue whether any adjustment  
38 is needed at all.

39  
40 The proposed rule on the 2024 Medicare physician fee schedule that was released on July 13 revised  
41 the utilization estimate for G2211 that they used to calculate the budget neutrality adjustment from  
42 the 90 percent previously announced in 2021 to 38 percent, significantly reducing the impact on  
43 payments.

44  
45 The AMA also secured another hardship exemption that physicians can claim under MIPS to avoid  
46 up to -nine percent in performance penalties in 2025.

47  
48 On November 2, 2023, the CMS released the 2024 Medicare Physician Payment Schedule final rule  
49 reducing the 2024 Medicare CF by 3.37 percent. These cuts result from a -1.25 percent reduction in  
50 the temporary update to the CF under current law and a negative budget neutrality adjustment  
51 stemming in large part from the adoption of the new G2211 office visit add-on code. Unfortunately,

1 these cuts coincide with ongoing growth in the cost to practice medicine as CMS projects a 4.6  
2 percent Medicare Economic Index (MEI) increase for 2024.

3  
4 Despite comments from the AMA and others that the G2211 add-on code is ambiguous and there is  
5 uncertainty about when to report it, CMS did not further reduce the utilization estimate or the  
6 associated budget neutrality impact. Specifically, CMS maintained its estimate from the proposed  
7 rule that the add-on code will be reported with 38 percent of office visits in 2024.

8  
9 Notably, in response to organized medicine’s advocacy, CMS maintained the performance threshold  
10 to avoid a penalty in the Merit-based Incentive Payment System (MIPS) at 75 points in 2024. As a  
11 result, 78 percent of eligible clinicians are expected to avoid a MIPS penalty in 2026, a significant  
12 improvement from CMS’ earlier projection that just over half of eligible clinicians would avoid a  
13 penalty in the proposed rule.

#### 14 15 *Federation Engagement*

16  
17 A Medicare Reform Workgroup comprised of staff from national medical specialty societies and  
18 state medical associations was organized in 2022 and has continued to meet to develop consensus on  
19 medicine’s reform proposals and advocacy strategies. The AMA also participates in a second  
20 coalition, organized by the American College of Radiology, which involves non-physician clinicians  
21 who bill under the Medicare fee schedule to expand our reach and minimize potential for divergent  
22 proposals and strategies.

23  
24 Periodic telephone conference calls are held with staff for Federation organizations to keep them  
25 apprised of developments in Washington and to elicit their support for grassroots efforts.

#### 26 27 *Grassroots, Media, and Outreach*

28  
29 The AMA has maintained a continuous drumbeat of grassroots contacts through its Physicians  
30 Grassroots Network, Patients Advocacy Network, and its Very Influential Physicians program. Op  
31 eds have been placed in various publications from AMA leaders, as well as from “grasstops”  
32 contacts in local newspapers. Digital advertisements are running, targeted specifically to  
33 publications read on Capitol Hill, and media releases have been issued to highlight significant  
34 developments.

35  
36 The AMA relaunched a dedicated Medicare payment reform web site, [www.FixMedicareNow.org](http://www.FixMedicareNow.org),  
37 which includes a range of AMA-developed advocacy resource material, updated payment graphics  
38 and a new “Medicare basics” series of papers describing in plain language specific challenges  
39 presented by current Medicare payment policies and recommendations for reform.

#### 40 41 2023 Fix Medicare Now Campaign Top Line Results

- 42  
43 • 425,900+ FixMedicareNow.org Page views  
44 • 173,60000+ FixMedicareNow.org Site Visitors  
45 • 40,679,400+ Impressions  
46 • 498,000+ Engagements  
47 • 1,200+ #FixMedicareNow Social Media Mentions  
48 • 450+ FixMedicareNow.org Advocacy Hub User Submissions  
49 • 288,000+ Contacts to Congress

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

5  
6 CONCLUSION

7  
8 As we forge ahead in continued partnership with the Federation to advance organized medicine's  
9 collective goals in our strategic mission to reshape the Medicare physician payment system, the  
10 AMA remains unwavering in its commitment to successfully pursuing the four pillars discussed in  
11 this report. Our steadfast dedication ensures that our members' voices are heard, and that we  
12 advocate for a system that is fair, sustainable, and reflective of the value physicians bring to patient  
13 care.

14  
15 Facing a nearly 10 percent reduction in Medicare payments over the past four years, physicians are  
16 at a breaking point and are struggling to maintain access to care for the Medicare beneficiaries they  
17 treat. Rising practice costs, workforce shortages, and financial uncertainty coupled with the  
18 continued lack of positive Medicare payment updates is threatening the viability of physician  
19 practices. This is unsustainable and unacceptable.

20  
21 While there has been some progress so far in 2024, significant advocacy work remains in the year  
22 ahead and beyond to achieve our vision of Medicare physician payment reform.

23  
24 Please follow Advocacy Update, join the Physicians Grassroots Network, visit  
25 [www.FixMedicareNow](http://www.FixMedicareNow) often for updated material and alerts, and follow other AMA  
26 communications vehicles to stay up to date and engaged on this topic.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 20-A-24

Subject: Criminalization of Providing Medical Care  
(Res. 015-A-23)

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

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

4  
5 [S]tudy the changing environment in which some medical practices have been  
6 criminalized including the degree to which such criminalization is based or not  
7 based upon valid scientific findings, the degree to which this is altering the actual  
8 practice of medicine due to physician concerns and personal risk assessment, and  
9 the degree to which hospitals and health care systems are responding to this rapidly  
10 changing environment, with report back to the HOD no later than the November  
11 2023 Interim meeting.

12  
13 This report is submitted for the information of the HOD.

14  
15 BACKGROUND

16  
17 *Abortion*

18  
19 On June 24, 2022, the U.S. Supreme Court issued its landmark decision in *Dobbs v. Jackson*  
20 *Women’s Health Organization*, holding that the U.S. Constitution does not confer a constitutional  
21 right to abortion and returned the authority to regulate abortion to the states. As of the writing of  
22 this report in March 2024, 14 states (Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana,  
23 Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, and West  
24 Virginia) prohibit the provision of nearly all abortions, two states (Georgia and South Carolina)  
25 prohibit abortion after fetal cardiac activity is detected around six weeks of pregnancy, and nine  
26 states (Arizona, Florida, Iowa, Kansas, Nebraska, North Carolina, Ohio, Utah, and Wisconsin)  
27 prohibit abortion later in pregnancy, but before the point at which a fetus is generally considered  
28 viable. Many of those latter nine states have passed laws prohibiting abortion earlier in pregnancy  
29 that have been blocked in court. Importantly, the status of state abortion laws is fluid. Legal  
30 challenges are ongoing in nearly two dozen states and the legality of abortion in those states is  
31 subject to change.

32  
33 At the time the *Dobbs* decision was published, 13 states had abortion prohibitions that predated the  
34 *Roe v. Wade* decision or so-called “trigger laws” that became effective upon the overruling of *Roe*,  
35 including several that were enacted in 2022 just prior to the *Dobbs* decision. In August 2022, the  
36 Indiana legislature became the first in the country to pass a post-*Dobbs* abortion ban. West Virginia  
37 followed in September 2022, and in 2023, seven states enacted new abortion bans. North Dakota  
38 and Wyoming enacted near-total bans; Florida, Iowa, and South Carolina enacted six-week bans;

1 and Nebraska and North Carolina enacted 12-week bans. Not all the newly enacted laws are in  
2 effect.

3  
4 Some, but not all, state abortion bans are punishable with criminal penalties. In other states,  
5 violations are subject to professional discipline up to mandatory revocation of the health care  
6 professional's license. Some also authorize civil enforcement of abortion bans by private citizens,  
7 though courts have declined to authorize those suits.

8  
9 Each state abortion ban contains an exception or affirmative defense, under specified conditions,  
10 when abortion is necessary to preserve the life of pregnant women and other pregnant patients.  
11 Most, but not all of the states' laws, also contain exceptions or affirmative defenses when abortion  
12 is necessary to prevent serious health consequences (e.g., "serious and irreversible impairment of a  
13 major bodily function"). Some laws also contain exceptions or affirmative defenses in cases where  
14 the pregnancy was due to rape or incest or when the fetus is diagnosed with a serious condition  
15 incompatible with life.

16  
17 These exceptions, however, are not crafted in a way that aligns with the complexity of medical  
18 practice and have led to significant confusion about how to practice medicine when pregnancy  
19 complications arise. As a result, physicians report significant uncertainty in navigating the new  
20 restrictions and describe a chilling effect on the practice of medicine that extends beyond obstetrics  
21 and gynecology into a range of specialties including emergency medicine, oncology, rheumatology,  
22 cardiology, psychiatry, and others. The AMA is not aware of data that can reliably quantify the  
23 degree to which medical practice has been altered in response to abortion restrictions but  
24 understands the impact on physicians, their practice, and their patients to be immense. Media  
25 reports have profiled numerous patients who describe harrowing experiences in which they  
26 suffered preventable medical complications because legal restrictions prevented medical  
27 professionals from providing recommended treatment. Similarly, in a lawsuit seeking to clarify the  
28 scope of Texas' medical emergency exception, 22 women describe being denied medically  
29 necessary and potentially lifesaving treatment when they were experiencing medical emergencies  
30 during their pregnancies.<sup>1</sup> To better track these cases, researchers at the University of California in  
31 San Francisco have undertaken a study, "*The Care Post-Roe Study*," to collect stories from  
32 clinicians about how abortion laws have altered the usual standard of care. In May 2023,  
33 preliminary findings described 50 cases in which abortion laws resulted in delays, worsened health  
34 outcomes, and increased the cost and logistic complexity of care.<sup>2</sup> Additionally, qualitative research  
35 published in January 2024 reported on obstetrician-gynecologists' perceived impacts of abortion  
36 bans.<sup>3</sup> The 54 research participants described delays in medical care, institutional restrictions on  
37 referrals and patient counseling, and inability to provide appropriate medical care. The research  
38 also reported high rates of moral distress and other personal impacts among the participants.

39  
40 Risk-averse hospitals and institutional policies are also likely to contribute to changes in medical  
41 practice. In May 2023, the Centers for Medicare & Medicaid Services announced investigations  
42 into two Missouri hospitals that allegedly withheld necessary stabilizing care to a pregnant patient  
43 experiencing preterm premature rupture of membranes in violation of the Emergency Medical  
44 Treatment and Labor Act.<sup>4</sup> The government's announcement stated that, in one situation, although  
45 the patient's doctors advised her that her pregnancy was no longer viable and her condition could  
46 rapidly deteriorate, they could not provide her with the care that would prevent infection,  
47 hemorrhage, and potentially death due to hospital policies. Physicians have described other similar  
48 hospital policies in which non-clinicians determine whether and at what point abortion care may be  
49 provided.

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

15  
16 Conversely, health care professionals in states that do not severely restrict access to abortion have  
17 reported an increase in demand for abortion care from out-of-state patients, as well as greater  
18 complexity of cases and abortion care, sought later in pregnancy. The #WeCount initiative reported  
19 in October 2023 that the increase in abortions provided in these states was greater than the decrease  
20 of abortion provided in restrictive states and notes that much of the increase has been in states that  
21 border restrictive states.

22  
23 Abortion bans are also likely to impact the physician workforce. Though data is not available, there  
24 have been anecdotal reports of individual physicians opting to leave states with restrictive laws.  
25 Similarly, two hospitals in Idaho closed their labor and delivery units, citing difficulties in  
26 recruiting staff and the hostile legal environment.<sup>8</sup> The American Association of Medical Colleges  
27 (AAMC) also reported that obstetrics and gynecology residency applications declined significantly  
28 in states that have banned abortion.<sup>9</sup> AAMC posits that restrictive abortion laws may deter  
29 applicants from applying to programs in those jurisdictions.

30  
31 The AMA is not aware of any investigation, criminal prosecution, or medical board disciplinary  
32 action taken against a physician for the illegal provision of abortion in a state with a strict  
33 prohibition. The lack of enforcement action coupled with the data described above from restrictive  
34 states suggests that physicians are complying with the laws and have ceased providing prohibited  
35 abortion care except when a legally recognized exception applies.

### 36 37 *Gender-affirming Care for Minor Patients*

38  
39 As of the writing of this report in March 2024, 23 states have enacted bans on gender-affirming  
40 care for minor patients. Twenty-one states (Alabama, Arkansas, Florida, Georgia, Iowa, Idaho,  
41 Indiana, Kentucky, Louisiana, Mississippi, Montana, Missouri, North Carolina, North Dakota,  
42 Ohio, Oklahoma, South Dakota, Tennessee, Texas, Utah, and West Virginia) broadly prohibit the  
43 provision of gender-affirming care to minor patients, including medications to delay puberty,  
44 hormonal therapy, and surgeries. Two states (Arizona and Nebraska) prohibit surgical interventions  
45 on patients younger than 18 years of age but do not ban non-surgical interventions. Legislative  
46 prohibitions on gender-affirming care have been relatively recent developments. The Arkansas  
47 legislature enacted the first such law in 2021, followed in 2022 with legislation in Alabama and  
48 Arizona and administrative action in Florida and Texas. Twenty-two states then enacted bans in  
49 2023 and 2024.

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

6  
7 Some laws have been successfully challenged in court. Arkansas's law has been permanently  
8 enjoined, and laws in Florida, Idaho, and Montana have been temporarily enjoined in whole or part.  
9 Like abortion laws, the status of laws regulating the provision of gender-affirming care is subject to  
10 change as legal challenges progress.

11  
12 At the start of 2023, no law was in effect that broadly prohibited gender-affirming care for minors,  
13 though some clinicians and institutions, including in Texas and Tennessee, paused care for minors  
14 in response to political pressure.<sup>10</sup> Many laws have since gone into effect, but the full impact is not  
15 yet known. It is reasonable to expect that physicians will cease to provide gender-affirming care to  
16 their minor patients in compliance with state law. It is also expected that the impact may extend to  
17 services provided to transgender adults, as well. For instance, the University of Mississippi  
18 Medical Center, which also treated adults, recently closed its gender clinic in response to legislative  
19 activity.<sup>11</sup> Conversely, health care professionals in states that protect gender-affirming care may  
20 experience increased demand for services. In contrast to abortion services, however, gender-  
21 affirming care generally requires ongoing treatment and monitoring, which could complicate  
22 patients' ability to travel to distant locations for care. Additionally, while the impact of state laws  
23 on patients and the LGBTQ+ community is immense, those patient outcomes are beyond the scope  
24 of this report.

#### 25 *Treatment of Patients with Pain and those with a Substance Use Disorder*

26  
27  
28 The nation's overdose and death epidemic was—and continues to be—driven by a complex set of  
29 factors, including the current dominance of illicitly manufactured fentanyl; illicit use of drugs such  
30 as heroin, cocaine, and methamphetamine; new toxic adulterants such as xylazine and nitazenes;  
31 and a lack of access to evidence-based care for pain or a substance use disorder. The history of the  
32 epidemic also includes actions of physicians and other health care professionals essentially  
33 engaging in drug dealing through what is colloquially termed, “pill mills.”<sup>12</sup> As part of its  
34 enforcement efforts, several years ago, the U.S. Department of Justice Criminal Division launched  
35 a “Prescription Strike Force,” which targets “Medicare Part-D fraud and other schemes involving  
36 false or fraudulent representations related to prescription medications, in addition to the illegal  
37 prescribing, distribution, and diversion of pharmaceutical-grade controlled substances.”<sup>13</sup> The U.S.  
38 Drug Enforcement Administration (DEA) regularly issues news releases highlighting convictions  
39 and other actions against physicians, nurse practitioners and pharmacists for crimes related to  
40 “illegally prescribing opioids.”<sup>14</sup>

41  
42 The AMA continues to be concerned about how the actions of the DEA and others in law  
43 enforcement have led to what has been referred to as a “chilling effect” in treating patients with  
44 pain. In a qualitative review of interviews with 20 West Virginia physicians, the review authors  
45 found that physicians' feared discipline even as opioid prescribing was decreasing. Specifically,  
46 physicians “felt that taking on patients who legitimately required opioids could jeopardize their  
47 career.”<sup>15</sup> Stories of patient harm and physician fear are abundant and disturbing to read.<sup>16</sup> But it is  
48 important to note that government intrusion into the practice of treating patients with pain or with a  
49 substance use disorder has existed for more than 100 years.<sup>17</sup> The Board of Trustees feels strongly  
50 that the AMA must continue its decades-long tradition of strongly advocating against third-party



1 intrusion, which includes but is not limited to government intrusion, into the patient-physician  
2 relationship.

3  
4 Notably, ensuring access to evidence-based care for patients with pain or with a substance use  
5 disorder remains top priorities for the work of the AMA and the AMA Substance Use and Pain Care  
6 Task Force (SUPCTF). AMA advocacy was vital to securing revisions to the 2016 Centers for  
7 Disease Control and Prevention (CDC) opioid prescribing guideline. AMA advocacy remains  
8 critical in advocating against misapplication of the 2016 CDC opioid prescribing guideline by  
9 payers, states, pharmacy chains, pharmacy benefit managers, and others. AMA advocacy also  
10 continues to work to remove all barriers to treatment for substance use disorders. This includes  
11 helping to lead the national discussion that unequivocally advocates for the understanding that  
12 substance use disorders are medical diseases and not moral failings. The Board of Trustees is  
13 grateful to the organizations in the SUPCTF for their partnership in furthering these efforts.

14  
15 Ultimately, it is difficult to specifically quantify the degree to which fear of law enforcement in  
16 treating pain or substance use disorders has altered the actual practice of medicine. There is ample  
17 anecdotal evidence, but limited research about physician concerns and personal risk assessment.  
18 The fear is real, and our colleagues and patients have suffered as a result. In response, AMA will  
19 continue to advance its policy opposing third-party/government intrusion into individualized  
20 patient care decisions.

## 21 22 DISCUSSION

23  
24 Opposing third-party intrusion into the practice of medicine (including but not limited to  
25 governmental intrusion) has long been a core priority for the AMA. The AMA continues to execute  
26 a multifaceted strategy, including engagement with policymakers at the state and federal levels,  
27 judicial advocacy, and more, to counter the deleterious impact of legislative efforts to criminalize  
28 the practice of medicine. The AMA Advocacy Resource Center continues to work extensively with  
29 state medical associations and national medical specialty societies, both publicly and behind-the-  
30 scenes, to oppose state laws and regulations targeting the practice of medicine.

31  
32 Additionally, development of the AMA Task Force to Preserve the Patient-Physician Relationship  
33 When Evidence-Based, Appropriate Care Is Banned or Restricted (Task Force), established by the  
34 HOD during the 2022 Annual Meeting, is in progress and the Task Force will update the HOD on  
35 its activities, as instructed in Policy D-5.998, "Support for Physicians Practicing Evidence-Based  
36 Medicine in a Post Dobbs Era." The Task Force is well-suited to address the issues raised in this  
37 report and will help guide organized medicine's response to the criminalization of medical practice,  
38 as well as identify and create implementation-focused practice and advocacy resources on the  
39 issues identified in Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician  
40 Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," including but not  
41 limited to:

- 42  
43 1. Health equity impact, including monitoring and evaluating the consequences of abortion  
44 bans and restrictions for public health and the physician workforce and including making  
45 actionable recommendations to mitigate harm, with a focus on the disproportionate impact  
46 on under-resourced, marginalized, and minoritized communities;
- 47  
48 2. Practice management, including developing recommendations and educational materials  
49 for addressing reimbursement, uncompensated care, interstate licensure, and provision of  
50 care, including telehealth and care provided across state lines;

- 1       3. Training, including collaborating with interested medical schools, residency and fellowship  
2       programs, academic centers, and clinicians to mitigate radically diminished training  
3       opportunities;  
4
- 5       4. Privacy protections, including best practice support for maintaining medical records  
6       privacy and confidentiality, including under HIPAA, for strengthening physician, patient,  
7       and clinic security measures, and countering law enforcement reporting requirements;  
8
- 9       5. Patient triage and care coordination, including identifying and publicizing resources for  
10      physicians and patients to connect with referrals, practical support, and legal assistance;  
11
- 12     6. Coordinating implementation of pertinent AMA policies, including any actions to protect  
13      against civil, criminal, and professional liability and retaliation, including criminalizing  
14      and penalizing physicians for referring patients to the care they need;  
15
- 16     7. Anticipation and preparation, including assessing information and resource gaps and  
17      creating a blueprint for preventing or mitigating bans on other appropriate health care, such  
18      as gender affirming care, contraceptive care, sterilization, infertility care, and management  
19      of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications; and  
20
- 21     8. Making recommendations including policies, strategies, and resources for physicians who  
22      are required by medical judgment and ethical standards of care to act against state and  
23      federal laws.  
24

## 25 CONCLUSION

26  
27       The Board of Trustees reiterates its support and gratitude for physicians and all health care  
28       professionals who confront the reality of law enforcement or other government intrusion into  
29       the practice of medicine. These intrusions have sometimes caused irreparable harms to  
30       physicians and patients across the United States. The AMA recognizes that law enforcement  
31       plays an important role in our society, but it should not in the exam room, operating suite, or  
32       any other patient-physician encounter. Whether it is through the Task Force to Preserve the  
33       Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or  
34       Restricted to protect access to reproductive rights and gender-affirming care, the Substance Use  
35       and Pain Care Task Force to enhance evidence-based care for patients with pain or a substance  
36       use disorder; or other areas that must confront the criminalization of health care, the AMA will  
37       continue to fight to protect and preserve the sacred nature of the patient-physician relationship.

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## EXECUTIVE SUMMARY

**BACKGROUND:** Policy D-440.922, “Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems,” adopted by House of Delegates 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 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

The AMA’s current priorities around public health are as follows:

1. Promote evidence-based clinical and community preventive services.
2. Respond to public health crises impacting physicians, patients, and the public. This includes addressing the threat of climate change, preventing firearm injuries and deaths, being prepared for emerging and remerging infectious disease threats, and ending the nation’s drug overdose epidemic.
3. Strengthen the health system through improved collaboration between medicine and public health.
4. Combat the spread of misinformation and disinformation.

## 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.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 22-A-24

Subject: AMA Public Health Strategy: Update

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

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1 BACKGROUND

2  
3 Policy D-440.922, “Full Commitment by our AMA to the Betterment and Strengthening of Public  
4 Health Systems” adopted by House of Delegates (HOD) at I-21 directed our American Medical  
5 Association (AMA) to:

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

10  
11 Policy D-145.992, “Further Action to Respond to the Gun Violence Public Health Crisis” has also  
12 called for the AMA to report annually to the House of Delegates on our AMA’s efforts relating to  
13 legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.  
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16 critical public health work to the HOD. Note that updates on the AMA’s work on climate change,  
17 firearm violence, and the mental health crisis were provided at I-23.  
18

19 DISCUSSION

20  
21 *What is Public Health?*

22  
23 Since its founding in 1847, the AMA’s mission has been “to promote the art and science of  
24 medicine and the betterment of public health.” According to the Centers for Disease Control and  
25 Prevention (CDC), public health is “the science and art of preventing disease, prolonging life, and  
26 promoting health through the organized efforts and informed choices of society, organizations,  
27 public and private communities, and individuals.”<sup>1</sup> Public health promotes and protects the health  
28 of people and the communities where they live, learn, work and play.<sup>2</sup> Public health practice is a  
29 different field than clinical medicine with different motivating values, responsibilities, and goals.<sup>3</sup>  
30 While a doctor treats people who are sick, those working in public health try to prevent people  
31 from getting sick or injured in the first place. A public health professional’s duty is to the  
32 community rather than an individual patient.  
33

34 *Connection with Health Equity*

35  
36 It is important to acknowledge that health equity is a central concept in public health and is  
37 essential to improving the health of populations. The AMA’s health equity strategy recognizes that  
38 structural and social drivers of health inequities shape a person’s and community’s capacity to  
39 make healthy choices, noting that downstream opportunities provided by the health care system

1 and individual-level factors are estimated to only contribute 20 percent to an individual’s overall  
2 health and well-being, while upstream opportunities of public health and its structural and social  
3 drivers account for 80 percent of impact on health outcomes.<sup>4</sup> The AMA develops an annual report  
4 on health equity activities. Progress towards the health equity strategy is reported in the BOT’s  
5 annual health equity report. (See BOT Report 10, “Center for Health Equity Annual Report.”)  
6

## 7 AMA PUBLIC HEALTH AND PREVENTION ACTIVITIES

### 8 9 **1. Promote evidence-based clinical and community preventive services.**

10  
11 *A. Serve as a liaison to the U.S. Preventive Services Task Force (USPSTF), the Advisory*  
12 *Committee on Immunization Practices (ACIP), and the Community Preventive Services Task Force*  
13 *(CPSTF) and support the dissemination of recommendations to physicians.*  
14

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

17 Examples include:

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

1 health care reform that includes evidence-based prevention insurance coverage for all; (2)  
2 evidence-based prevention in all appropriate venues, such as primary care practices,  
3 specialty practices, workplaces, and the community.  
4

5 *B. Help prevent chronic diseases, with a focus on cardiovascular disease, by addressing major risk*  
6 *factors (AMA Strategic Priority led by the Improving Health Outcomes Group)*  
7

8 The AMA is committed to improving the health of the nation and reducing the burden of chronic  
9 diseases. Our primary focus is preventing cardiovascular disease (CVD), the leading cause of death  
10 in the U.S., accounting for 1 in 4 deaths among adults.<sup>5-7</sup> Two major risk factors for CVD are  
11 hypertension and type 2 diabetes. An estimated 122 million adults have hypertension; 98 million  
12 have prediabetes and are at increased risk for developing type 2 diabetes.<sup>7,8</sup>  
13

14 CVD risk factors and associated morbidity and mortality inequitably impact Black,  
15 Hispanic/Latinx, Indigenous, Asian/Pacific Islanders, and other people of color. Black adults are  
16 more than twice as likely to die of CVD relative to white adults.<sup>9</sup> Black adults have higher  
17 prevalence rates for diabetes compared to Hispanic (22 percent compared to 19 percent).<sup>10</sup> While  
18 specific causes of the inequities vary by each respective group; structural and societal barriers are  
19 attributed as primary reasons.  
20

21 To prevent CVD and address related health inequities, the AMA is developing and disseminating  
22 CVD prevention solutions in collaboration with health care and public health leaders. These  
23 solutions educate clinical care teams and patients, guide health care organizations (HCOs) in  
24 clinical quality improvement and promote policy changes to remove barriers to care. The AMA  
25 disseminates these solutions through strategic alliances with various organizations including the  
26 CDC, the American Heart Association (AHA), and West Side United in Chicago.  
27

28 The AMA MAP™ Hypertension clinical quality improvement program was designed to improve  
29 hypertension management and control. The program has been provided to 46 HCOs across 20  
30 states since 2019. Among those HCOs, 38 percent were in systems that provide free or low-cost  
31 care to historically marginalized populations. The AMA MAP™ set of solutions is expanding to  
32 include management for other cardiovascular disease risk factors, including cholesterol,  
33 prediabetes, and post-partum hypertension.  
34

35 Additionally, in response to the high prevalence of uncontrolled blood pressure and to support  
36 physicians in managing their patients' high blood pressure, the AMA, in collaboration with AHA,  
37 developed Target: BP™, a national initiative offering a series of online resources, using the latest  
38 evidence-based information. Target: BP™ recognizes organizations that have achieved milestones  
39 in their commitments to improving blood pressure control. In 2023, Target: BP™ 1,709 HCOs  
40 participated in the Target: BP™ Achievement Awards including 868 HCOs that reported control  
41 rates greater than or equal to 70 percent and/or 1,493 HCOs that attested to evidence-based blood  
42 pressure measurement practices, like using the US Validated Blood Pressure Device Listing  
43 (VDL™). Participants came from 47 states or U.S. territories and served about 33 million patients,  
44 including 8.6 million people with hypertension.  
45

46 AMA Prevent Diabetes houses a suite of tools and resources designed to help organizations build  
47 and integrate diabetes prevention strategies into their organizations. AMA has worked with more  
48 than 80 health care organizations across the country to increase identification and management of  
49 patients with prediabetes. This suite of tools and resources and AMA's related expertise served as  
50 the basis for the Bright Spot Model, which provided structure for local initiatives in Philadelphia  
51 and North Carolina to advance diabetes prevention. AMA has since transitioned the Bright Spot

1 model to the CDC who is now expanding the reach of the model by funding four organizations  
2 with \$10 million for implementation. As part of this implementation, CDC is requiring funded  
3 organizations to work with HCOs to implement the AMA Prediabetes Quality Measures. AMA  
4 will continue to make our suite of tools and resources available to support this effort.

5  
6 In 2023, the AMA in its partnership with the AHA, closed Medicaid coverage gaps to ensure that  
7 beneficiaries could receive home blood pressure devices and have their condition monitored by  
8 physician-led care teams. The AMA was also successful in closing a Medicare coverage gap;  
9 hemoglobin A1c lab tests are now a covered screening test which could result in more high-risk  
10 individuals getting screened, diagnosed, and referred to a preventive intervention.

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

16  
17 *C. Collaborate with CDC to improve the implementation of routine screening for HIV, STI, Viral*  
18 *Hepatitis and latent tuberculosis (LTBI).*

19  
20 Through funding from the CDC, the AMA has been engaged in a project entitled, “Promoting HIV,  
21 Viral Hepatitis, STDs and LTBI Screening in Hospitals, Health Systems and Other Healthcare  
22 Settings.” The scope of this project includes developing, piloting and launching a toolkit that  
23 outlines ways to increase routine screening for HIV, STIs, viral hepatitis and LTBI. The toolkit  
24 consists of a series of webpages on the AMA’s website. Information and strategies are organized  
25 along the screening and testing continuum and offer helpful resources and best practices from the  
26 AMA, CDC and other organizations. The toolkit contains two different sets of strategies – one  
27 targeted to community health centers and a second to emergency departments.

28  
29 On October 1, 2023, the AMA launched a pilot with four emergency departments, after completing  
30 a community health center pilot earlier in the year. The emergency department pilot cohort  
31 includes: Harris Health Ben Taub Hospital (staffed by Baylor College of Medicine physicians and  
32 residents), Mayo Clinic, University of Colorado and Valleywise Health. Each pilot site selected 2-3  
33 quality improvement strategies outlined in the routine screening toolkit to implement in their  
34 emergency department. Sites also provided tangible feedback to the AMA on the effectiveness of  
35 these strategies and ease of implementation in addition to providing input on the overall toolkit  
36 itself. The AMA held a series of telementoring sessions for the pilot sites, which were moderated  
37 by Megan Srinivas, MD, MPH and Marc Mendelsohn, MD. The pilot sites will conclude their  
38 implementation work and post-pilot assessment activities by the end of April 2024.

39  
40 Upon addressing critical feedback we received on the toolkit during a mid-point usability study  
41 with the emergency department pilot sites, we launched the toolkit to the public with a press release  
42 on March 6, 2024.<sup>12</sup> In conjunction with the launch of the toolkit, we are hosting a three-part  
43 webinar series that highlights key strategies to improve routine screening. The series will be hosted  
44 by AMA President Jesse Ehrenfeld, MD, MPH. The first episode in the series will feature Jonathon  
45 Mermin, MD, MPH, director, National Center for HIV, STIs, Viral Hepatitis and LTBI at the  
46 CDC.<sup>13</sup>

47  
48 *D. Promote evidence-based preventive services to the public in collaboration with the Ad Council*  
49 *and other health partners.*



1 While the AMA's primary audience is physicians, there are limited instances where the AMA has  
2 partnered on public information campaigns on select priority issues. This work has been made  
3 possible through partnerships with other health-related organizations and the Ad Council. The  
4 AMA will explore opportunities for future campaigns on an ongoing basis, with recognition that  
5 we must prioritize our efforts and engaging in these campaigns alone is not feasible due to cost.  
6

7 Get My Flu Shot. The Ad Council, AMA, CDC and the CDC Foundation have partnered since the  
8 2020-2021 flu season through an annual campaign to motivate more people to get vaccinated  
9 against seasonal influenza (flu) to protect themselves and their loved ones. During a severe season,  
10 flu has resulted in as many as 41 million illnesses and 710,000 hospitalizations among the U.S.  
11 population. The Get My Flu Shot campaign PSAs are launched nationwide to reach people with the  
12 message that a flu shot can help you stay healthy, reduce risk of severe outcomes, such as  
13 hospitalization and death, and avoid missing work, school, or special moments with family and  
14 friends. PSAs are available to run in English and Spanish across all platforms, in donated time and  
15 space throughout flu season. The campaign ads direct audiences to [GetMyFluShot.org](https://www.getmyflushot.org) for more  
16 information, including where to get a flu vaccine in their area. Some highlights from the 2023-24  
17 flu campaign are as follows:  
18

- 19 • The donated media value for the current Flu season reached nearly \$8.8M. The most  
20 support has come from out of home (OOH - \$4,500,471), closely followed by TV support  
21 (\$3,794,079).
- 22 • A media tour was held on September 19, 2023, in English and Spanish, featuring  
23 spokespeople from the AMA, including Willie Underwood, MD, MSc, MPH and Madelyn  
24 Butler, MD, and representatives from the CDC. Nearly 300 placements were secured  
25 across TV, radio, and digital, with a reach of 2 million viewers (18 years of age or older),  
26 53.8 million digital impressions, and 2.3 million broadcast impressions.
- 27 • A second media tour was held on December 12, 2023, in English and Spanish, with  
28 spokespeople from the AMA, including Willie Underwood, MD, MSc, MPH and the CDC.  
29 Nearly 100 placements across TV, radio, and digital were secured with a reach of 3.2  
30 million viewers (18 years of age or older), 191.1 million digital impressions, and 3.5  
31 million broadcast impressions.
- 32 • We partnered with Influential and Black Girl Digital for our trusted messenger activation  
33 on social media. There was a total of 11M impressions, an estimated reach of 2.5M, 65k  
34 engagements, and 9k link clicks. There was an overall positive sentiment (81 percent)  
35 towards the posts.
- 36 • PSA awareness is now 56 percent in Black and Hispanic respondents based off our most  
37 recent December 2023 tracking study.  
38

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

40

41 The AMA's public health work has also been focused around responding to public health crises.  
42 These crises are often associated with significant health risk for patients, raising concerns among  
43 physicians. However, these crises are unlikely to be solved in a clinical setting alone. The AMA's  
44 response to public health crises are typically focused on (1) ensuring physicians and trainees have  
45 the data and resources needed; (2) identifying evidence-based policies and interventions; (3)  
46 elevating the voices of physician leaders through AMA channels and platforms; and (4) convening  
47 and collaborating with stakeholders to advance priority policies and interventions.  
48

49 *A. Address the public health crisis of climate change.*

1 At the 2022 Annual Meeting of the House of Delegates, policy was adopted declaring “climate  
2 change a public health crisis that threatens the health and well-being of all individuals.” Since the  
3 A-23 meeting, AMA has accomplished the following activities and is developing a formal strategy  
4 to address climate change and health (anticipated release is the AMA I-24 meeting):  
5

- 6 • The AMA has made climate change education available via the Ed Hub™ from a variety of  
7 sources including the AMA Journal of Ethics (JOE), the Journal of the American Medical  
8 Association (JAMA), and the American Public Health Association (APHA).
- 9 • AMA's Chief Health & Science Officer, Frederick Chen, MD, MPH, joined the August 24,  
10 2023, PermanenteDocs Chat podcast on heat waves and health, with a focus on how  
11 physicians can adjust to prepare to care for heat-related conditions brought on by climate  
12 change.
- 13 • JAMA announced the introduction of its new climate change and health series.<sup>14</sup> The new  
14 series is intended to inform readers about the associations between climate change and  
15 health and “to stimulate improved knowledge and understanding of the health effects of  
16 climate change to help foster commitment to timely action to prevent adverse health events  
17 from climate change.”
- 18 • The AMA is in the process of developing a new CME module for physicians and trainees  
19 on climate change and health which is anticipated to be available in summer 2024. The  
20 focus of the module is to bring awareness to physicians about the impact of climate change  
21 on the nation’s health and to empower physicians to begin conversations with their patients  
22 about how climate change is affecting their health and what they can do about it.
- 23 • The AMA created a new webpage on AMA’s website, *Advocacy in action: Combating*  
24 *health effects of climate change*, to highlight AMA’s position on this issue, how it is  
25 engaged, and resources for physicians.<sup>15</sup>
- 26 • On November 2, 2023, AMA Update featured Victor Dzau, MD, President of the National  
27 Academy of Medicine (NAM), to discuss how their Action Collaborative on  
28 Decarbonizing the U.S. Health Sector is bringing together organizations across health care  
29 to take action on climate change.<sup>16</sup>
- 30 • At the Interim 2023 meeting, the Health, Science, and Ethics business unit, in collaboration  
31 with NAM, hosted an educational session entitled *The Climate Crisis: Pathways to*  
32 *Decarbonizing the U.S. Health Sector*. The session featured four speakers who spoke to  
33 ways that health care professionals can lead meaningful and measurable changes in  
34 combating climate change, identified common barriers to decarbonization, and provided  
35 available resources to support action towards decarbonization. Although overall attendance  
36 was not counted, 48 individuals claimed CME credit for attending the event and the  
37 average quality rating was 4.8/5.0.
- 38 • In early spring 2024, the AMA STEPS Forward® Podcast featured Jerry Abraham, MD,  
39 MPH, who discussed the intersections between the social determinants of health and  
40 climate change impacts.
- 41 • The AMA submitted an abstract to the American Public Health Association (APHA)  
42 annual conference to be held in October 2024 to present on the findings from the listening  
43 sessions held with physicians in May 2023 on climate change and health.
- 44 • The AMA continues to engage in the Medical Society Consortium on Climate and Health  
45 (Consortium), which brings together associations representing over 600,000 clinical  
46 practitioners.<sup>17</sup> The AMA sits on the executive committee of this group, represented by Ilse  
47 Levin, DO, MPH & TM. Additionally, the AMA was a sponsor of the MSCCH Annual  
48 Meeting held in February 2024 in Washington, DC. Dr. Levin and AMA staff attended the  
49 meeting.

- 1 • The AMA is also a member of the NAM Action Collaborative on Decarbonizing the  
2 Health Sector as a member of the Steering Committee and co-lead of the Health Care  
3 Delivery Workgroup.
  - 4 ○ The first phase (2021-2023) of the Action Collaborative's work has been focused  
5 on identifying key opportunities and challenges to climate action, decarbonization,  
6 and building resiliency across the health sector and developing resources and tools  
7 to meet those needs. The collaborative, through the work of the members have  
8 completed over thirty resources to accelerate climate action across the health  
9 sector.
  - 10 ○ The second phase (2024-2025) will consist of accelerating a national climate and  
11 health movement, as well as advancing the successes of the existing working  
12 groups and launching an accelerator pilot program.
- 13 • The AMA is represented on the APHA Center for Climate, Health, and Equity Advisory  
14 Board. In February 2024, the Advisory Board organized a roundtable of public health  
15 experts to discuss the health, climate and equity priorities for consideration of the  
16 reauthorization of the federal transportation bill, which is scheduled to be renewed in 2025.
- 17 • The AMA was also represented at APHA's first Climate, Health and Equity Summit in late  
18 February 2024, which brought together professionals from across multiple disciplines to  
19 explore the intersectionality of climate, health and equity and strategize how professionals  
20 can advance public health and climate justice.

21

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

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

45

#### 46 *B. Prevent firearm injuries and deaths.*

47

48 In the 1980's the AMA recognized firearms as a serious threat to the public's health as weapons are  
49 one of the main causes of intentional and unintentional injuries and deaths. At the 2016 Annual  
50 Meeting, following the Pulse nightclub shooting, policy was adopted declaring that "gun violence

1 represents a public health crisis which requires a comprehensive public health response and  
2 solution." Since that time firearm injuries and deaths have increased and disparities have  
3 widened.<sup>20</sup>

- 4
- 5 • The AMA is participating in the Health Professional Education and Advocacy/Policy  
6 committees of the Healthcare Coalition for Firearm Injury Prevention, which is being led  
7 by American Academy of Pediatrics (AAP), American College of Emergency Physicians  
8 (ACEP), American College of Physicians (ACP), American College of Surgeons (ACS),  
9 and the Council of Medical Specialty Societies (CMSS).<sup>21</sup>
- 10 • On October 25–26, 2023, Alexander Ding, MD, MS, MBA, represented the AMA at the  
11 Milken Institute’s Innovation Forum on Preventing Gun Violence in San Francisco. This  
12 first-of-its-kind convening explored how technologies, expanded community collaboration,  
13 and innovative models could unlock real progress to prevent gun violence and address its  
14 societal repercussions.
- 15 • On December 14, 2023, the AMA convened the Firearm Injury Prevention task force for  
16 an in-person meeting held at AMA Headquarters in Chicago. Willie Underwood, MD,  
17 MSc, MPH, Chair of the AMA Board of Trustees and the task force led the meeting along  
18 with task force Co-Vice Chairs Toluwalasé (Lasé) Ajayi, MD, and Alexander Ding, MD,  
19 MS, MBA. Representatives to the task force discussed their organization priorities on  
20 firearm injury prevention, examined the possibility of creating a resource center on firearm  
21 injury prevention for physicians that would include information for patients and resources  
22 on evidence-based interventions, and discussed the development of a toolkit for physicians  
23 on extreme risk protection orders.
- 24 • On February 7, 2024, the AMA was represented by Willie Underwood, MD, MSc, MPH,  
25 at the Northwell Health’s Gun Violence Prevention Forum in New York City.
- 26 • On March 4, 2024, the AMA convened a virtual meeting of the Firearm Injury Prevention  
27 task force, where the members had the opportunity to hear from the Ad Council both about  
28 their ongoing gun violence work as well as their new campaign, funded by members of the  
29 National Health Care CEO Council on Gun Violence Prevention and Safety. The new  
30 campaign seeks to elevate the issue of gun violence in America and its impact on youth,  
31 shifting away from divisive, politically charged conversations to those focused on public  
32 health approaches that have proven effective in combating this epidemic.
- 33

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

- 39 • On April 19, 2023, the AMA joined more than 400 national, state, and local medical,  
40 public health, and research organizations in a letter to the leadership of the House and  
41 Senate Committees on Appropriations asking that for Fiscal Year (FY) 2024 they  
42 appropriate \$35 million for the CDC, \$25 million for the NIH, and \$1 million for the NIJ to  
43 conduct public health research into firearm morbidity and mortality prevention.
- 44

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

- 48 • Legislative Document (LD) 2237 - An Act to Strengthen Public Safety, Health and Well-  
49 being by Expanding Services and Coordinating Violence Prevention Resources. AMA  
50 policy supports many of the initiatives in this comprehensive legislation, and applauds the

1 investment in violence prevention strategies, access to behavior health services, suicide  
2 prevention, and crisis intervention programs. (Policies H-145.975, D-345.972, H-345.972,  
3 and H-60.937)

- 4 • LD 2086 - An Act to Amend the Law Governing the Disposition of Forfeited Firearms.  
5 The AMA supports removal of firearms from prohibited persons. (Policy H-145.972)
- 6 • LD 2224 - An Act to Strengthen Public Safety by Improving Maine’s Firearm Laws and  
7 Mental Health System. AMA Policy advocates for a waiting period and background check  
8 for all firearm purchasers and policies that prevent transfer of firearms without adhering to  
9 background checks. The AMA also applauds efforts to expand access to mental health and  
10 substance use disorder treatment. (Policies H-145.996 and H-145.975)
- 11 • LD 2238 - An Act to Address Gun Violence in Maine by Requiring a Waiting Period for  
12 Certain Firearm Purchase. AMA Policy supports legislation that enforces a waiting period  
13 and background check for all firearm purchasers. (Policy H-145.996)

14  
15 Through the AMA's litigation center, we work to represent the interests of the medical profession  
16 on this issue in the courts by providing support or becoming actively involved in litigation of  
17 importance to physicians.

- 18  
19 • On August 21, 2023, the AMA was joined by the AAP, the ACS, the AP HA and the Texas  
20 Medical Association in submitting an amicus brief in the case of *U.S. vs. Rahimi*, which  
21 was argued on November 7, 2023, before the U.S. Supreme Court. The case challenges a  
22 1994 law adopted by Congress to keep firearms out of the hands of people who are the  
23 subject of a domestic violence restraining order (DVRO). The brief shares firsthand  
24 accounts from 17 physicians who have witnessed the devastating injuries and deaths  
25 caused by domestic abusers with firearms, as well as the often-lifelong psychological terror  
26 inflicted upon victims, their children, and others.
- 27 • On December 26, 2023, the AMA was joined by the AAP, ACP, and ACS in submitting an  
28 amicus brief in the case of *Garland v. Cargill*. The case involves firearms, namely whether  
29 a bump stock device is a machinegun under federal law, as it allows users to convert a  
30 semiautomatic firearm into a weapon that fires continuously with a single trigger pull. The  
31 brief presents the firsthand experiences of physicians who treat victims of firearm violence  
32 and explains why semi-automatic weapons with bump stocks are a critical public health  
33 hazard, and prohibiting bump stocks saves lives.

34  
35 The AMA has created a website broadly outlining the organization's advocacy efforts on gun  
36 violence prevention.<sup>22</sup>

37  
38 *C. Respond to emerging and remerging infectious disease threats and prepare for future*  
39 *pandemics.*

40  
41 Infectious diseases continue to evolve and advance throughout the U.S. Pathogens that were once  
42 geographically limited are now advancing beyond those traditional borders. Blastomycosis,  
43 Histoplasmosis and Coccidioidomycosis are all fungal infections that have pushed past expected  
44 boundaries. In addition to organisms known to be found in the U.S., tropical diseases like malaria,  
45 dengue and Leishmaniasis have all been found in the U.S. in nontravelers. Re-emerging pathogens  
46 like measles continue to find footholds across the country. While it’s unclear what the next  
47 infectious diseases outbreak will bring, the U.S. health system must be ready. Because the AMA is  
48 relied upon as a source of information by physicians and patients, the AMA must maintain the  
49 ability to respond and share information and advocate for physicians, patients, and the public in  
50 line with AMA policies.

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

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

30  
31 *D. End the nation's drug overdose epidemic.*

32  
33 Ending the nation's drug overdose epidemic will require increased physician leadership, a greater  
34 emphasis on overdose prevention and treatment, and better coordination and amplification of the  
35 efforts and best practices already occurring across the country.

36  
37 The AMA makes education available to physicians on this topic via the AMA Ed Hub™ to help  
38 physicians gain critical knowledge around acute and chronic pain management, substance use  
39 treatment, overdose prevention, and pain treatment to meet the regulatory requirements. Courses  
40 are developed by AMA as well as by other partners. The AMA is also a member of the Providers  
41 Clinical Support System (PCSS), which is made up of a coalition of major health care  
42 organizations all dedicated to addressing this health care crisis and is led by the American  
43 Academy of Addiction Psychiatry. PCSS provides evidence-based training and resources to give  
44 health care providers the skills and knowledge they need to treat patients with opioid use disorders  
45 and chronic pain.<sup>24</sup>

- 46  
47 • In 2023 the AMA worked to update content and resources for the physician education  
48 series of module *Practical Guidance or Pain Management*. This content was made  
49 available to help physicians meet the DEA's MATE Act requirements.

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- 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.<sup>25</sup>
  - 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.

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

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

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- 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).<sup>26</sup> 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:
    - Coordination between health care and public health
    - Always-on emergency preparedness
    - Real-time disease detection
    - Exchange 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

1 explained the commitments the Coalition has made and actions each organization will take  
2 to create a strong public health system and healthier future for all.  
3

4 **4. Combat the spread of misinformation and disinformation.**  
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6 The AMA remains engaged in external collaborations to address mis- and disinformation, such as  
7 the Coalition for Trust in Health & Science and the recently rebranded physician-focused coalition,  
8 Mitigating Medical Misinformation Workgroup.  
9

- 10 • The Coalition for Trust in Health & Science’s vision is for all people to have equitable  
11 access to accurate, understandable, and relevant information to make personally  
12 appropriate health choices and decisions. The AMA is an active member, engaging with  
13 leadership and participating in programming.
- 14 • The AMA is also an active participant in the Mitigating Medical Misinformation  
15 Workgroup and supported its recent research that found primary care physicians were  
16 viewed as the most trusted source for medical information. The AMA will work with this  
17 group to disseminate these findings to a broader audience in 2024 and will continue to  
18 coordinate efforts internally to ensure alignment.
- 19 • The AMA filed an amicus brief with the U.S. Supreme Court in the case of *Murthy v.*  
20 *Missouri*. The brief focuses on how disinformation diminished uptake of COVID-19  
21 vaccines, which then limited the vaccines’ ability to save lives by controlling the spread of  
22 disease—thereby creating a compelling interest for the government to act. The high court  
23 will hear oral arguments in the case on March 18, 2024.  
24

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



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# REPORT OF THE BOARD OF TRUSTEES

B of T Report 24-A-24

Subject: Report on the Preservation of Independent Medical Practice

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

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## 1 BACKGROUND

2

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

7

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

12

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

15

## 16 DISCUSSION

17

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

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

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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%).

1 The Section has held formal Business Meetings at all AMA Annual and Interim meetings since  
2 June of 2021. Attendance has been strong, fluctuating between approximately 40 and 60 members  
3 attending each meeting. The PPPS has advanced 18 resolutions to the House of Delegates since the  
4 2022 Annual Meeting on topics such as reexamining laws around physician self-referrals, limiting  
5 corporate ownership of private practices, improving Medicare reimbursement, and developing  
6 guidelines for the use of virtual and overseas administrative assistants, among many others.

7  
8 The AMA has championed issues important to private practice in its advocacy efforts, particularly  
9 at the federal level. Key among these issues is reforming Medicare payment rates to ensure  
10 practices can continue to thrive. The AMA believes the need to stop the annual cycle of pay cuts  
11 and patches and enact permanent Medicare payment reforms could not be clearer. The AMA was  
12 successful in getting Congress to introduce H.R. 2474, the Strengthening Medicare for Patients and  
13 Provider Act, which would provide automatic, annual payment updates to account for inflation as  
14 reflected in the Medicare Economic Index (MEI). The AMA and our Physician Grassroots  
15 Network and Patient Advocacy Network consider the passage of H.R. 2474 to be among its highest  
16 priorities.

17  
18 The AMA is also engaging directly with federal decision-makers on fixing prior authorization,  
19 limiting scope creep, supporting telehealth, surprise billing, and protecting against government  
20 intrusion in areas such as abortion care and gender-affirming care. The AMA has submitted  
21 comments on the Federal Trade Commission’s proposed rule on noncompete agreements and  
22 Department of Justice antitrust merger guidelines. The AMA also advocates before Congress and  
23 the Centers for Medicare and Medicaid Services that the Stark exemption for physician-owned  
24 hospitals needs to be restored.

25  
26 The cyber security attack on Change Healthcare in March 2024 has left many independent  
27 physician practices struggling to stay on top of their operations. The AMA is working closely with  
28 members who have experienced disruptions to share instructions for getting federal emergency  
29 funds, guides for managing impact, and connecting physicians’ experiences directly to the United  
30 States Department of Justice.

### 31 32 *Outreach to Independent Physicians*

33  
34 For the past three years, the PPPS has hosted a virtual Private Practice Townhall each March or  
35 April, serving as an open forum for independent physician members to raise issues they may be  
36 experiencing in their practices and share ideas for addressing them. The Townhall not only  
37 provides valuable real-world intelligence about the issues private practices are experiencing to the  
38 leadership of the PPPS, but it also affords an opportunity for physicians to connect as peers to share  
39 tips and best practices. Additionally, the Townhall typically inspires ideas for education sessions at  
40 PPPS Business Meetings as well as generates new policy proposals.

41  
42 The PPPS has also collaborated with the AMA’s Professional Satisfaction and Practice  
43 Sustainability (PS2) team. The two are currently planning a private practice “bootcamp” to be held  
44 in advance of the 2024 Annual Meeting. The “bootcamp” will be a multi-hour training session on  
45 the business of private practice, giving attendees opportunities to better understand how to  
46 effectively manage their business while continuing to provide care to patients. The program stems  
47 from ideas raised in previous PPPS Townhalls as well as open discussions at PPPS Business  
48 Meetings and other AMA events.

1 *Promoting Resources for the Advancement of Independent Practices*

2  
3 The AMA's STEPS Forward® initiative, part of its Innovation Academy, has made a suite of  
4 interactive open-access resources tailored for independent practices available through the AMA  
5 EdHub™, many of which are available for continuing medical education credit. These include  
6 podcasts, toolkits, and webinars available online to members and non-members.

7  
8 Specifically, STEPS Forward® has crafted a series of tools and materials designed to help  
9 physicians who are either new to private practice or who simply seek to better operationalize their  
10 practice. Key examples include:

- 11
- 12 • 7 STEPS to Starting a Private Practice visual guide
- 13
- 14 • Private Practice Playbook – a repository of sample forms including a model new patient  
15 packet, routine patient documents such as medical release and patient payment plans,  
16 administrative documents such as refund requests and medication logs, employee  
17 documents for job descriptions and expense reimbursement, and new hire documents such  
18 as model confidentiality agreements and drug screen consent forms.
- 19

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

28  
29 The PPPS has offered additional educational programming at its Annual and Interim meetings.  
30 Designed and curated to address issues that PPPS members most frequently raise as key issues for  
31 their practice, the Section routinely works with internal and external subject matter experts to share  
32 strategies and information to attendees. Recent examples of educational sessions offered at PPPS  
33 meetings include a legal analysis of employment contracting from the perspective of both the  
34 employer and employee, an unpacking of innovative business model strategies from three different  
35 independent physician practices, a strategic assessment of methods for transitioning a practice, and  
36 a breakdown of best practices for branding and marketing.

37  
38 **CONCLUSION**

39  
40 The AMA continues to be mindful of the rate of change in the physician practice setting with  
41 greater numbers of physicians opting to leave private practice each year. The strategies and  
42 initiatives outlined here represent the foundations the AMA will build upon to continue to ensure  
43 that independent physician practices have the support they need to thrive. The AMA will continue  
44 to promote the resources it has while expanding its menu of services and tools geared toward  
45 physicians in private practice.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 27-A-24

Subject: AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates (Resolution 606-A-23)

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

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

7  
8 Resolution 606 asked:

9  
10 That our American Medical Association develop a reimbursement policy consistent with  
11 established AMA travel policies for reasonable travel expenses that any state or national  
12 specialty society is eligible to receive reimbursement for its delegate’s and alternate delegate’s  
13 actual expenses directly related to the necessary business functions required of its AMA  
14 delegates and alternate delegates in service to the AMA at HOD meetings, including travel,  
15 lodging, and meals; and

16  
17 That each state or national specialty society requesting such reimbursement for its delegate’s  
18 and alternate delegate’s reasonable travel expenses will submit its own aggregated  
19 documentation to the AMA in whatever form is requested by the AMA.

20  
21 BACKGROUND

22  
23 Resolution 606 highlighted the significance of the AMA HOD as a policy making body with  
24 diverse voices being represented through the delegations. The resolution focuses on the costs that  
25 are incurred by the organizations sending delegates and alternates to the meetings without  
26 discussing the costs of the meeting to the AMA. The resolution pointed out that several state and  
27 specialty medical societies are facing financial hardships due to several factors, including declining  
28 membership. As these organizations are looking to cut costs, not sending the full delegations or  
29 alternate delegates to the AMA HOD meetings could be seen as a savings. In some instances,  
30 delegates pay their own expenses at AMA HOD meetings so they can be a part of the robust policy  
31 making process. In addition, medical students and residents expressed issues with obtaining  
32 funding and are seeking inclusion in the development of an AMA reimbursement policy.

33  
34 *Costs*

35  
36 A fiscal note of \$8.1 million was the estimate of the ongoing additional annual costs that would be  
37 incurred by the AMA if this resolution were adopted. This would be in addition to the \$12 million  
38 the AMA is spending already to hold HOD meetings and provide staff support for councils,

1 sections and special groups. That does not include costs related to responding to and implementing  
2 resolutions from the HOD.

3  
4 While our AMA has experienced above normal operating income over the last several years due to  
5 a reduction in expenses during the pandemic office closures and a record number of open positions  
6 due to tight labor markets, it is expected that the Association will return to full employment and  
7 regular operations by 2024, with a reversion to normal budgeted income.

8  
9 *AMA Budget and Reserve Policies*

10  
11 In the early 2000's, AMA's financial picture was very poor evidenced by questions raised at the  
12 HOD about the long-term viability of the organization. The AMA Board took action in 2000 to  
13 implement financial policies that would provide for ongoing sustainable operations and  
14 programmatic activities for both the short-and long-term. The goal was two-fold: 1) ensure that  
15 AMA would be able to withstand short-term volatility in revenue without requiring elimination of  
16 programs or personal that would be harmful to AMA's reputation and 2) create reserve assets that  
17 could serve as a quasi-endowment fund to help ensure long-term fiscal stability of the organization.  
18 The annual budget policy was in answer to the first goal and that policy requires that AMA budget  
19 a surplus equal to the inflationary impact on two- to three-year's operating expenses. The reserve  
20 policy prohibits the use of reserves for ongoing operating expenses in order to avoid drawing down  
21 the reserves on an annual basis and thus impairing the ability to maintain and grow reserves for the  
22 long-term stability of the organization, i.e., AMA's quasi-endowment fund.

23  
24 The two policies cited above mean that any expenditures above the current budget levels will  
25 require reducing expenses from other areas of the annual budget, i.e., other programmatic  
26 activities. If this resolution were adopted, that would result in an ongoing annual \$8 million cost  
27 reduction in other programs, which at the current rate of inflation would cost almost \$100 million  
28 over the next ten years. In addition, the size of the HOD continues to increase and this will drive  
29 total costs of delegates and alternate delegates attending in-person meetings higher than levels cited  
30 above, regardless of whether it is paid by AMA or the societies.

31  
32 Financial and Tax Implications

33  
34 AMA's tax-exempt status and the regulations under which it operates to maintain that status is a  
35 key consideration when determining if or how to provide benefits or contributions to individuals or  
36 organizations. As an example, AMA's tax counsel has advised that generally the IRS has found  
37 that the provision of financial benefits to members in certain situations will constitute private  
38 inurement which will result in the loss of tax-exempt status. Counsel did advise that the IRS has  
39 consistently viewed paying the reasonable travel expenses of volunteers, particularly those who  
40 participate in governance, as being acceptable and not treated as compensation which in this case  
41 would cover delegates and alternate delegates and thus led to the language of the resolution  
42 submitted to the HOD.

43  
44 Additional discussions with tax counsel have resulted in another potential alternative, i.e.,  
45 providing travel grants to societies in the HOD to cover or partially cover direct out-of-pocket  
46 expenses for delegates and alternate delegates based on financial need. Under this alternative,  
47 counsel recommended the following criteria: 1) the travel grants be limited to societies that  
48 demonstrate financial need; 2) the travel grants should be specifically identified as grants to cover  
49 travel reimbursement only for voting delegates and alternate delegates who participate in the HOD  
50 meetings, enabling delegates to participate in discussions regarding important issues affecting  
51 AMA and the medical profession; 3) the grant agreement between AMA and the society should

1 require that the funds are for reimbursement of incurred travel expenses in a manner that is  
2 consistent with 501(c)(6) purposes; and 4) that AMA should establish a cap on the amount that any  
3 one society can receive for reimbursement of travel expenses.

4

5 Based on the above alternative, AMA performed an analysis of the financial status of those  
6 societies seated in the HOD. The 2022 Form 990's submitted to the Internal Revenue Services  
7 were obtained for 178 constituent and specialty societies. Form 990's were not available for seven  
8 societies.

9

10 In 2022, the combined revenues and assets of the 178 societies total \$3.2 billion and \$7 billion  
11 respectively, and although there is wide disparity in the resources of these societies, is substantially  
12 more than AMA's revenue or assets. The estimated average cost of a delegate and alternate  
13 delegate attending the AMA meetings is approximately \$11,400. At revenue levels of \$2.5 million  
14 and above, the total average cost for delegates and alternates would range from 0.04% to 2.1% of  
15 annual revenue. In comparison, AMA currently spends 2.6% of its total annual revenue on HOD  
16 activities.

17

18 The AMA realizes the importance of representation and participation in the policy-making process  
19 and the strength of organized medicine, are the organizations who send representatives to our HOD  
20 meetings to participate in the policy making process. Your Board of Trustees presents this report as  
21 informational as we continue to study options for strengthening the participation of the Federation  
22 in House of Delegates meetings. Your Board will submit a report at the 2025 Annual Meeting.



# REPORT OF THE BOARD OF TRUSTEES

B of T Report 32-A-24

Subject: Independent Medical Evaluation

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

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1 At the 2023 Annual Meeting, the House of Delegates referred Resolution 007, “Independent  
2 Medical Evaluation,” to the Board of Trustees. Resolution 007 specifically asked:

3  
4 That our American Medical Association study and report back at the 2024 Annual Meeting on  
5 the Independent Medical Evaluation (IME) process and recommend standards and safeguards  
6 to protect injured and disabled patients. (Directive to Take Action)

7  
8 The resolution was referred to the Board of Trustees for decision in September 2023. At that  
9 meeting, the Board of Trustees reviewed the Management report and decided to complete the  
10 study, as outlined in the report.

11  
12 The following study, presented as an informational report, examines IME standards, processes and  
13 procedures that impact the rights of examinees and physicians throughout the IME process, as set  
14 forth in the resolution. Topics discussed include professional qualifications, ethics, objectivity,  
15 safety, and access.

16  
17 Despite their widespread use, IME processes and approaches can significantly vary across different  
18 jurisdictions, which may impact the rights and responsibilities of examinees and physicians.  
19 Examining specific jurisdictional regulation protocols such as codes of ethics, educational  
20 requirements and licensure protocols are beyond the purview of this report.

## 21 22 PURPOSE AND DEFINITION OF INDEPENDENT MEDICAL EVALUATIONS (IME)

23  
24 In general, an IME is “a usually one-time evaluation performed by an independent medical  
25 examiner who is not treating the patient or claimant, to answer questions posed by the party  
26 requesting the IME”.<sup>1</sup> The most common purpose of an IME is to provide a timely, impartial, and  
27 objective assessment of an examinee’s medical condition to determine appropriate diagnoses,  
28 causality, the extent of injuries or disabilities, and need for accommodation. This is often required  
29 in the context of legal or insurance matters. Unless a limited scope IME is stipulated by the  
30 requesting party or refused by the examinee, an IME includes the essential element of a medical  
31 assessment, specific to the defined scope of the requested evaluation, including history,  
32 examination, and review of relevant records and diagnostic studies.<sup>3</sup>

33  
34 The goal of the IME physician is to provide an unbiased, evidence-based assessment regarding the  
35 individual's medical status, including the nature and extent of injuries or disabilities. During an  
36 IME, the examinee’s relevant medical history, current condition, test results, functional status, and  
37 any relevant medical records are assessed. The *AMA Guides to the Evaluation of Permanent*  
38 *Impairment* (AMA Guides) provide a reliable measurement framework for assessing permanent  
39 impairment and are required in many jurisdictions.<sup>1,2</sup> An impairment rating may be a component of

1 the IME, which is defined as a “consensus-derived percentage estimate of loss of activity, which  
2 reflects severity of impairment for a given health condition, and the degree of associated limitations  
3 in term of Activities of Daily Living (ADLs)”.<sup>1</sup> The AMA Guides Editorial Panel ensures the AMA  
4 Guides are up to date with the latest evidence-based medicine and science.

5  
6 While IMEs and corresponding processes vary among different contexts and jurisdictions, one  
7 commonality is that there is no patient-physician relationship, and many jurisdictions avoid using  
8 the term “patient” in the context of IMEs because this can be construed to establish a patient-  
9 physician relationship. Instead, the term “examinee” is used.<sup>1,3,4</sup>

#### 10 11 *Common Scenarios for IMEs*

12  
13 The applications and requirements of an IME can differ significantly based on different scenarios.  
14 For example, in workers' compensation, IMEs commonly evaluate the nature and extent of  
15 occupational-related injuries, care-related issues and authorizations, physical work capabilities, and  
16 causality. For insurance claims, particularly those involving personal injury, bodily injury, and  
17 automobile accidents, IMEs can verify the legitimacy and extent of the alleged injuries and medical  
18 status. In many jurisdictions, an injured party’s failure to comply with insurer requests for an IME  
19 or a claim investigation to support a claims determination may be grounds for a denial of the claim  
20 and benefits. Additionally, IMEs are utilized in legal disputes or tort litigation involving alleged  
21 bodily, physical, mental, or other injury claims. Petitioner filings, court or other findings may result  
22 in an IME order to obtain an objective assessment of injuries, disabilities, and/or other issues.

#### 23 24 PROFESSIONAL QUALIFICATIONS FOR INDEPENDENT MEDICAL EVALUATORS

25  
26 The selection of the medical professional with the appropriate qualifications is a fundamental  
27 aspect that can determine the examination's thoroughness and impact the outcome of claims,  
28 benefits, and legal disputes. Judges or juries critically assess the qualifications and expertise of the  
29 physician to ensure that their evaluation is reliable and based on sound medical judgment. The  
30 presence of established standards and resources for IME training and certification underscores the  
31 importance of having skilled, ethical, and unbiased medical professionals conduct these  
32 examinations within their scope of practice.

33  
34 Jurisdictional regulations or protocols may include specific criteria for physician qualifications.  
35 The following qualifications are commonly recommended across most jurisdictions:

- 36  
37
- 38 • Unrestricted license to practice medicine in the jurisdiction.
  - 39 • Relevant board-certification in a specialty recognized by the American Board of Medical  
40 Specialties.
  - 41 • Competency in report-writing and the ability to provide deposition and expert testimony  
42 are essential. These skills ensure that the physician can effectively communicate their  
43 medical findings and rationale in legal or insurance contexts.
  - 44 • Professional history should be free from adverse events that could compromise their  
45 credibility or impartiality in performing an IME.

46 Specialized credentials or certification may be required on a jurisdictional-specific basis.

#### 47 48 *Objectivity and Bias*

49  
50 The IME process should be objective, independent and unbiased with the substantiation of findings  
51 and recommendations based upon available information and evidence.<sup>3,4</sup> Physician transparency in

1 reporting and testimony can reinforce impartiality. Having IMEs performed in a timely manner in  
2 an appropriately situated and appointed environment is in the best interest of the examinee and  
3 involved parties. However, there may be conflicts of interest to consider.

4  
5 The *AMA Code of Ethics*<sup>5,6</sup> addresses the ethical considerations for physicians employed by  
6 businesses or insurance companies, as well as independent medical examiners assessing health or  
7 disability. The IME physician may obtain personal information about patients outside an ongoing  
8 patient-physician relationship, such as assessments for employers or insurers. It is also important to  
9 obtain written consent, as required by law, to provide disclosure to third parties.<sup>6</sup>

10  
11 While practicing in these roles, physicians have dual responsibilities to both the patient and the  
12 employer or third party. However, there is also the additional duty to uphold the obligations of a  
13 medical professional. Therefore, the following should be considered:<sup>5</sup>

- 14
- 15 • Disclose the nature of the relationship with the employer or third party before gathering
- 16 health information from the patient.
- 17 • Explain that the goal is to assess the patient's health or disability independently and
- 18 objectively, distinguishing it from the traditional fiduciary role of a physician.
- 19 • Protect patients' personal health information according to professional confidentiality
- 20 standards.
- 21 • Inform the patient about significant findings during the examination, suggesting follow-up
- 22 care from a qualified physician when appropriate.
- 23

## 24 PROTECTIONS FOR THE EXAMINEE

### 25 *Informed Consent*

26  
27  
28 It is important for examinees to understand their jurisdictionally specific rights and the potential  
29 implications of the examination's findings on their claims or legal cases. This information should  
30 be communicated to the examinee via the informed consent process. The examiner must explain  
31 that there is no physician-patient relationship involved and the evaluation is not a traditional  
32 medical evaluation conducted by their treating physician.<sup>3,4</sup> Additionally, the examinee must advise  
33 the examiner immediately if any problems are encountered during the evaluation and a report will  
34 be provided to the requesting client.

35  
36 Additional best practices for the informed consent process are as follows:<sup>4</sup>

- 37
- 38 • Discuss the importance of the examinee's reading and signing of a written informed
- 39 consent with the examinee prior to the evaluation.
- 40 • Establish the ground rules for the performance of the service.
- 41 • Provide the opportunity for the examinee to understand the rationale for the IME, who is
- 42 requesting the evaluation, and where the report will be sent.
- 43 • Ensure the examinee understands what the IME provider can and cannot do.
- 44 • Acknowledge that the examinee understands that there will be no physician-patient
- 45 relationship established.
- 46 • Confirm that there will not be a discussion regarding diagnoses nor any recommendations
- 47 for treatment.
- 48 • Indicate that the examinee is consenting to having their history taken and that an
- 49 examination will occur.
- 50 • Clearly state that the IME physician is independent and that any opinions developed are
- 51 given irrespective of anyone else involved in the claim (a third-party evaluation).

- 1 • State that there is an understanding that the results of the evaluation (the report) will only  
2 be given to the requesting party (unless there is a jurisdictional rule that requires something  
3 else).
- 4 • Spend an appropriate amount of time on the informed consent process to ensure that the  
5 IME physician can answer questions or clarify points that are not well understood.

#### 6 7 *IME Report Access*

8  
9 An examinee may have the right to access their IME report, but the process and ease of access can  
10 vary based on jurisdiction, the specific policies of the requesting entity (such as an insurance  
11 company or employer), and the purpose of the IME. There might be a specific timeframe within  
12 which the IME report must be requested or provided.

13  
14 Examinees should be encouraged to inquire about the request process or seek assistance from their  
15 legal representative to understand their rights and the best approach to obtain the IME report. These  
16 rights are often outlined in health information privacy laws or regulations concerning workers'  
17 compensation and personal injury cases. For IMEs conducted as part of an insurance claim or  
18 workers' compensation case, the report is typically part of the claim file. In the context of legal  
19 disputes, IME reports may become part of the discovery process, allowing the examinee or their  
20 attorney to access the report as part of the case proceedings.

#### 21 22 *Third-Party Observation*

23  
24 Some jurisdictions may have specific regulations or guidelines that address whether third-party  
25 observers are allowed during IMEs. Examinees and their representatives should clarify the rules  
26 and policies regarding third-party observers in advance. This might involve consulting with legal  
27 counsel, reviewing the request for the IME, and directly communicating with the requesting  
28 organization, insurance company, or physician coordinating the examination.

29  
30 The presence of a third-party observer raises issues of patient privacy, confidentiality, and integrity  
31 of the examination process, and research shows that it will bias the evaluation to the extent that in  
32 most cases, the results are invalid.<sup>4,7</sup> If a third party is allowed because of jurisdictional rule, the  
33 individual undergoing the IME and the third party should agree to confidentiality terms. Any  
34 observer will need to agree to not interfere with the examination.

#### 35 36 PROTECTIONS FOR PHYSICIANS

37  
38 The IME physician may be asked to render an opinion based upon incomplete information,  
39 inadequate records, a limited in person evaluation, or an examinee who is uncooperative or  
40 misrepresenting their true status for potential secondary gain. The examiner may be requested to  
41 report on the nature and extent of alleged, documented or observed injuries, and function based  
42 upon the available information and findings, within a reasonable degree of certainty.

43  
44 Despite challenges that may arise during an IME, the evaluating physician's goal remains to  
45 provide an unbiased, objective opinion regarding the examinee's medical and/or physical status.  
46 When possible, physicians should identify and request additional records and information if needed  
47 to objectively provide their report. Indicating that conclusive findings cannot be rendered with the  
48 available information may be necessary in some circumstances.

49  
50 In addition to examinee rights, the following list outlines best practices for minimizing professional  
51 risks for physicians conducting IMEs:

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- 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.<sup>6</sup>

#### 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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REPORT OF THE BOARD OF TRUSTEES

B of T Report 34-A-24

Subject: Demographic Report of the House of Delegates and AMA Membership

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

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1 INTRODUCTION

2

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

6

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

10

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

13

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

17

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

26

27 DATA SOURCES

28

29 Lists of delegates and alternate delegates are maintained in the Office of House of Delegates  
30 Affairs and are based on official rosters provided by the relevant society. The lists used in this  
31 report reflect 2023 year-end delegation rosters.

32

33 Data on individual demographic characteristics are taken from the AMA Physician Professional  
34 Data, which provides comprehensive demographic, medical education, and other information on all  
35 United States and international medical graduates (IMGs) who have undertaken residency training  
36 in the United States. Data on AMA membership and the total physician and medical student  
37 population are taken from the Masterfile and are based on 2023 year-end information.

38

39 Some key considerations must be kept in mind regarding the information captured in this report.  
40 Vacancies in delegation rosters mean that the total number of delegates is less than the 705 allotted

1 at the November 2023 Interim Meeting, and the number of alternate delegates is nearly always less  
 2 than the full allotment. As such, the total number of delegates and alternate delegates is 1091 rather  
 3 than the 1410 allotted. Race and ethnicity information, which is provided directly by physicians, is  
 4 missing for approximately 15 percent of AMA members and approximately 19 percent of the total  
 5 United States physician and medical student population, limiting the ability to draw firm  
 6 conclusions. Efforts to improve AMA data on race and ethnicity are part of Policy D-630.972.  
 7 Improvements have been made in collecting data on race and ethnicity, resulting in a decline in  
 8 reporting race/ethnicity as unknown in the HOD and the overall AMA membership.

9  
 10 **CHARACTERISTICS OF AMA MEMBERSHIP AND DELEGATES**

11  
 12 Table 1 presents basic demographic characteristics of AMA membership and delegates along with  
 13 corresponding figures for the entire physician and medical student population.

14  
 15 Data on physicians’ and students’ current activities appear in Table 2. This includes life stage as  
 16 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
<b>Age</b>			
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%
<b>Gender</b>			
Male	58.9%	61.9%	60.8%
Female	40.5%	37.2%	39.0%
Unknown	0.6%	0.9%	0.2%
<b>Race/Ethnicity</b>			
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%
<b>Education</b>			
US or Canada	81.3%	77.2%	90.6%
IMG	18.7%	22.8%	9.4%

<sup>1</sup> There were 319 vacancies as of year’s end.

<sup>2</sup> Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.

<sup>3</sup> Age as of December 31. Mean age is the arithmetic average.

<sup>4</sup> Includes other self-reported racial and ethnic groups.



Table 2. Life Stage, Present Employment and Self-Designated Specialty<sup>5</sup>, December 2021

2023	AMA Members	All Physicians and Medical Students	AMA Delegates & Alternate Delegates 1,2
<b>Life Stage</b>			
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%
<b>Present Employment</b>			
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%
<b>Specialty</b>			
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%

<sup>5</sup> See Appendix for a listing of specialty classifications.

<sup>6</sup> 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

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 6-A-24

Subject: Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

Presented by: David A. Fleming, MD, Chair

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1 At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a  
2 detailed explanation of its judicial function. This undertaking was motivated in part by the  
3 considerable attention professionalism has received in many areas of medicine, including the  
4 concept of professional self-regulation.  
5

6 CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove  
7 a membership application or to take action against a member. The disciplinary process begins when  
8 a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an  
9 applicant or member is reported to the AMA. This information most often comes from statements  
10 made in the membership application form, a report of disciplinary action taken by state licensing  
11 authorities or other membership organizations, or a report of action taken by a government tribunal.  
12

13 The Council rarely re-examines determinations of liability or sanctions imposed by other entities.  
14 However, it also does not impose its own sanctions without first offering a hearing to the physician.  
15 CEJA can impose the following sanctions: applicants can be accepted into membership without any  
16 condition, placed under monitoring, or placed on probation. They also may be accepted, but be the  
17 object of an admonishment, a reprimand, or censure. In some cases, their application can be  
18 rejected. Existing members similarly may be placed under monitoring or on probation, and can be  
19 admonished, reprimanded or censured. Additionally, their membership may be suspended or they  
20 may be expelled. Updated rules for review of membership can be found at [https://www.ama-  
21 assn.org/governing-rules](https://www.ama-assn.org/governing-rules).  
22

23 Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial  
24 activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA’s activities  
25 during the most recent reporting period is presented.

APPENDIX

CEJA  
*Judicial Function  
 Statistics*

APRIL 1, 2023 – MARCH 31, 2024

<b>Physicians Reviewed</b>	<b><u>SUMMARY OF CEJA ACTIVITIES</u></b>
<b>14</b>	<b>Determinations of no probable cause</b>
<b>22</b>	<b>Determinations following a plenary hearing</b>
<b>18</b>	<b>Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing</b>

<b>Physicians Reviewed</b>	<b><i>FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS</i></b>
<b>14</b>	<b>No sanction or other type of action</b>
<b>3</b>	<b>Monitoring</b>
<b>17</b>	<b>Probation</b>
<b>4</b>	<b>Revocation</b>
<b>5</b>	<b>Suspension</b>
<b>1</b>	<b>Denied</b>
<b>1</b>	<b>Suspension lifted</b>
<b>0</b>	<b>Censure</b>
<b>7</b>	<b>Reprimand</b>
<b>3</b>	<b>Admonish</b>

<b>Physicians Reviewed</b>	<b><u>PROBATION/MONITORING STATUS</u></b>
<b>20</b>	<b>Members placed on Probation/Monitoring during reporting interval</b>
<b>15</b>	<b>Members placed on Probation without reporting to Data Bank</b>
<b>10</b>	<b>Probation/Monitoring concluded satisfactorily during reporting interval</b>
<b>0</b>	<b>Memberships suspended due to non-compliance with the terms of probation</b>
<b>10</b>	<b>Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues</b>
<b>7</b>	<b>Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues</b>

REPORT 2 OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT (A-24)  
Scenarios on Collective Action and Physician Unions

EXECUTIVE SUMMARY

The AMA estimated in 1998 that between 14,000 and 20,000 physicians were union members. By 2014, that number grew to 46,689 (5.7 percent) of 820,152 actively practicing physicians in the United States; in 2019, there were 67,673 physician union members, 7.2 percent of the 938,156 physicians actively practicing in the United States and an approximate 26 percent increase from 2014 in the percentage of physicians belonging to unions. Additionally, in April 2022, In Piedmont Health Services, Inc. and Piedmont Health Services Medical Providers United, Case No. 10-RC-286648, Region 10 of the National Labor Relations Board (Region) issued a Decision and Direction of Election (DDE) in which it held that physicians are not supervisors under the National Labor Relations Act (NLRA) simply by virtue of their position in the health care institution and thus are eligible for union representation.

As more physicians and physicians in training enter large systems, employment and unions, their needs from professional organizations and trusted voices will change. For the AMA to continue most effectively in its role as the largest advocate for physicians in the United States, it will be essential to adapt to the changing practice environment and consider how to provide its constituents with timely and useful education and support.

To that end, the Council on Long Range Planning and Development (CLRPD) conducted a scenario-building exercise to consider how changes in the macro environment in which health care is delivered may impact the capabilities and goals of physician collective bargaining. The focal question considered by the Council was: How can our AMA support the empowerment of physicians and physicians in training through collective bargaining to provide the best possible care for patients?

This informational report presents the findings of that exercise, which focused on four critical uncertainties in the macro environment that were likely to impact physician needs: the overall strength of the U.S. economy, patient perception of quality of care, consequences/ethics of work stoppages, and working conditions.

The goals of this exercise were multifaceted. It allowed the Council to consider an extremely complex issue through the lenses of specific factors rather than generalities. It allowed the Council to consider how the capabilities and goals of collective bargaining would be likely to change based on overarching factors affecting the United States and health care environments. Finally, it allowed for dynamic consideration of how the needs of physicians and physicians in training, as well as the role of the AMA would necessarily change based on the shifting environments in which physicians will practice medicine.

# REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 2-A-24

Subject: Scenarios on Collective Action and Physician Unions

Presented by: Gary Thal, MD, Chair

---

1 BACKGROUND

2  
3 The AMA estimated in 1998 that between 14,000 and 20,000 physicians were union members. By  
4 2014, that number grew to 46,689 (5.7 percent) of 820,152 actively practicing physicians in the  
5 United States; in 2019, there were 67,673 physician union members, 7.2 percent of the 938,156  
6 physicians actively practicing in the United States and an approximate 26 percent increase from  
7 2014 in the percentage of physicians belonging to unions.<sup>1</sup> Over the same time period (1998-2019),  
8 the percentage of all U.S. workers in unions fell from 13.9 percent to 10.3 percent;<sup>2</sup> the proportion  
9 of physicians, residents and fellows in unions is increasing against the national trend of all workers.

10  
11 Additionally, in April 2022, In *Piedmont Health Services, Inc. and Piedmont Health Services*  
12 *Medical Providers United*, Case No. 10-RC-286648, Region 10 of the National Labor Relations  
13 Board (Region) issued a Decision and Direction of Election (DDE) in which it held that physicians  
14 are not supervisors under the National Labor Relations Act (NLRA) simply by virtue of their  
15 position in the health care institution and thus are eligible for union representation.<sup>3</sup>

16  
17 In its reasoning, the Region focused on the fact that the physician’s primary role is to provide  
18 health care to patients, not participate in the administrative and personnel functions reserved for  
19 other lead medical providers (who were excluded from the petitioned-for unit). The Region found  
20 that the physicians are not held responsible for the performance of other employees and provide  
21 only sporadic supervision. The Region specifically disputed the fact that some of the petitioned-for  
22 physicians were found to be the “supervising physician” of another credentialed provider, as  
23 required by North Carolina’s professional licensing law. The Region based this finding on a prior  
24 NLRB decision, which held that a governmental requirement that a health care provider be  
25 supervised by a physician does not necessarily establish the physician as a supervisor under the  
26 NLRA. This DDE confirmed that physicians will not automatically be considered supervisors  
27 under the NLRA and may seek union representation. Piedmont’s physicians and providers  
28 subsequently voted in favor of union representation. Prior to this decision, unionization among  
29 physicians had largely been confined to medical residents and public-sector physicians.<sup>4</sup>

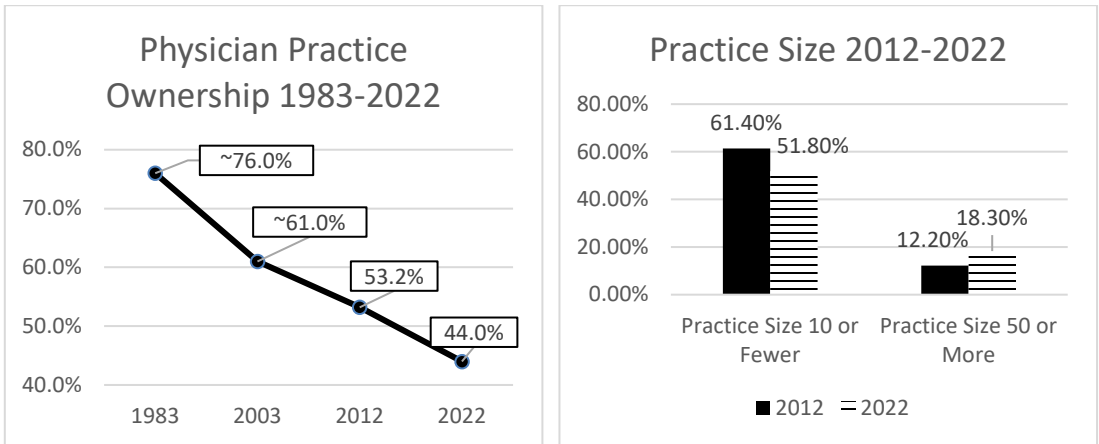
30  
31 Since that decision, frequent occurrences of unionizing among physicians, residents, and fellows  
32 have been observed:

- 33
- 34 • Roughly 400 primary and urgent-care providers across more than 50 clinics operated by  
35 the Allina Health System in Minnesota and Wisconsin voted to unionize in October 2023,  
36 appearing at the time to be the largest group of unionized private-sector physicians in the  
37 United States. More than 150 nurse practitioners and physician assistants at the clinics  
38 were also eligible to vote and became members of the union.<sup>5</sup> Further appeals by Allina  
39 were unsuccessful.<sup>6</sup>

- 1 • Physicians at six Legacy Health hospitals in Oregon and Washington voted to unionize; the  
2 vote was certified by the National Labor Relations Board November 17, 2023. The  
3 hospitalists’ decision to unionize had the stated goals of improving local health care and  
4 giving frontline physicians a voice in the decisions that impact their patients’ care,  
5 communities’ health and hospital working conditions. Approximately 200 hospitalists  
6 employed by Legacy Health joined the approximately 700 Oregon Nurses Association  
7 nurses and mental and behavioral health professionals already employed by the system,  
8 making it one of the largest hospitalist union groups in the country.<sup>7</sup>  
9
- 10 • In January 2024, residents and fellows at Northwestern University's McGaw Medical  
11 Center voted to unionize, citing concerns with a lack of information around pay increases  
12 and benefits from the health system. More than 1,300 residents and fellows were set to join  
13 the Committee of Interns and Residents/Service Employees International Union after  
14 nearly 800 voted in favor of the move. The Committee of Interns and Residents (CIR) is  
15 the largest housestaff union in the United States, representing over 32,000 resident  
16 physicians and fellows as of March 2024.<sup>8,9</sup>  
17

18 The most recently available list of hospital residency programs that have joined CIR has been  
19 included as an appendix. This list does not represent all unionized residency programs, and the  
20 number of unionized residency programs has continued to grow.  
21

22 Among the most significant drivers of increased unionization among physicians and physicians in  
23 training are undoubtedly the dramatic decrease in physician practice ownership, the related increase  
24 in the number of employed physicians, and the shift away from small practices. While current  
25 estimates on the number of employed physicians vary, with one recent study finding 73.9 percent  
26 of physicians to be employed by hospitals, health systems, or corporate entities,<sup>10</sup> an AMA Policy  
27 Research Perspective published in July 2023 found that, in 2022, 49.7 percent of physicians were  
28 employees, 44.0 percent were owners, and 6.4 percent were independent contractors. This  
29 represented a significant contrast to 2012 when 53.2 percent of physicians were owners, to the  
30 early and mid-2000s, when around approximately 61 percent of physicians were owners  
31 (Wassenaar and Thran 2003; Kane 2009), and the early 1980s when the ownership share was  
32 around 76 percent (Kletke, Emmons, and Gillis 1996). Practice size continued a redistribution of  
33 physicians from small practices to large ones. The percentage of physicians in practices with 10 or  
34 fewer physicians fell from 61.4 percent in 2012 to 51.8 percent in 2022. In comparison, the  
35 percentage in practices with 50 or more physicians grew from 12.2 percent to 18.3 percent.<sup>11</sup>



Source: Kane C. Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022. American Medical Association.

1 The analysis also found that in 2012, 44.3 percent of physicians under the age of 45 were owners.  
2 By 2022, only 31.7 percent of physicians under the age of 45 were owners. This suggests that a  
3 smaller percentage of each successive class of physicians has started their post-residency career in  
4 an ownership position. Furthermore, the employment status of young physicians is different than  
5 that of older physicians. In 2022, 51.3 percent of physicians aged 55 and over compared to 31.7  
6 percent of physicians under age 45 were owners. This indicates that when physicians retire, owners  
7 are not replaced in the workforce on a one-to-one basis; they are more likely to be replaced by  
8 physicians who are employees.<sup>12</sup>

9  
10 The moves away from practice ownership and into employment, and away from small practices  
11 and into large ones, seem likely to continue, if not accelerate, in the foreseeable future. As such, so  
12 too will the prevalence of physicians, residents and fellows who may consider unionization.

### 13 14 SCENARIO DEVELOPMENT

15  
16 As more physicians and physicians in training enter large systems, employment and unions, their  
17 needs from professional organizations and trusted voices will change. For the AMA to continue  
18 most effectively in its role as the largest advocate for physicians in the United States, it will be  
19 essential to adapt to the changing practice environment and consider how to provide its constituents  
20 with timely and useful education and support.

21  
22 To that end, CLRPD conducted a scenario-building exercise to extrapolate on how changes in the  
23 macro environment in which health care is delivered may impact the capabilities of physician  
24 collective bargaining. The Council identified the following focal question for this exercise:

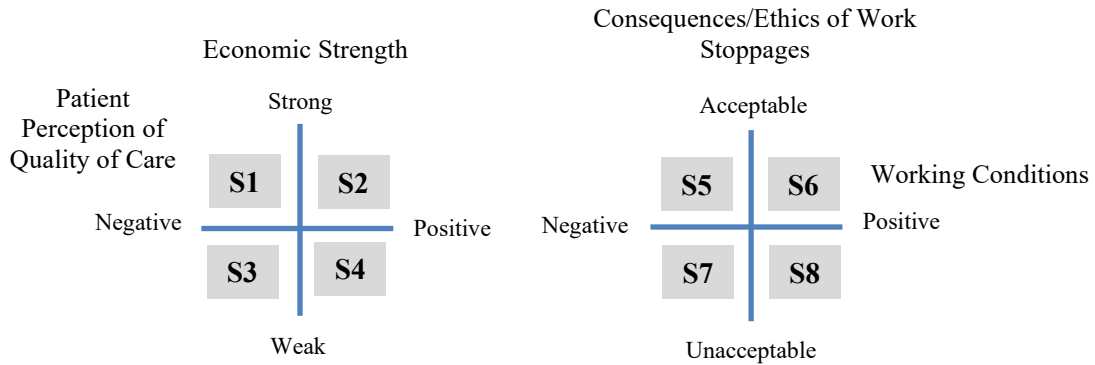
25  
26 *How can our AMA support the empowerment of physicians and physicians in training*  
27 *through collective bargaining to provide the best possible care for patients?*

28  
29 Based on this question, the Council identified a list of driving forces and factors in the overall  
30 environment that would influence the needs of physicians in different environmental scenarios.  
31 From this list, members were asked to rank each driver based on two metrics: (1) how important  
32 each one was to the focal question and (2) how uncertain the outcome of each driver was. The goal  
33 of this step was to identify both the most important and most uncertain driving forces (“critical  
34 uncertainties”). The Council identified the following critical uncertainties:

- 35  
36
- Overall strength of the U.S. economy
  - Patient perception of quality of care
  - Consequences/ethics of work stoppages
  - Working conditions
- 37  
38  
39  
40

41 These driving forces were subsequently combined into two matrices, from which were created  
42 eight distinct scenario spaces (S1-S8):





1 The Council considered what the implications of each scenario space would be for physicians and  
 2 patient care, and, subsequently, what role the AMA could play in supporting physicians in each  
 3 scenario. The goals of this exercise were multifaceted. It allowed the Council to consider an  
 4 extremely complex issue through the lenses of specific factors rather than generalities. It allowed  
 5 the Council to consider how the capabilities and goals of collective bargaining would be likely to  
 6 change based on overarching factors affecting the United States and health care environments.  
 7 Finally, it allowed for dynamic consideration of how the needs of physicians and physicians in  
 8 training, as well as the role of the AMA would necessarily change based on the shifting  
 9 environments in which physicians will practice medicine.

10  
 11 In the following section, the Council contemplated the world of each scenario space including the  
 12 connections between the two driving forces; how the interplay between those forces would affect  
 13 patients, physicians, and the health care environment; what the needs of physicians might be to  
 14 support the delivery of the best possible patient care; and how the AMA might be best positioned to  
 15 support those needs.

16  
 17 **SCENARIO SPACES**

18  
 19 **Scenario 1 – Strong Economy & Negative Patient Perception of Quality of Care**

20 In a scenario in which the economy is strong, but patients have a negative perception of quality of  
 21 care, the Council identified several challenges and opportunities. In terms of opportunities, the  
 22 Council noted that in times of economic prosperity, the position of unions, and the overall position  
 23 from which physicians could collectively bargain would be enhanced. Most obviously, employers  
 24 in such a scenario would have opportunities to make payment concessions. This could be of  
 25 particular benefit to residents and fellows, to whom payment and quality of life relative to working  
 26 hours is an ongoing concern. More directly related to the negative perception of quality of care,  
 27 physicians in such a scenario would likely be able to advocate and negotiate toward changes in  
 28 health systems and care delivery that would enhance patient satisfaction. For instance, physicians  
 29 negotiations could work toward allowing physicians to spend more time with individual patients,  
 30 which can lead to increased patient satisfaction.<sup>13</sup> Furthermore, improvements in how a clinic is  
 31 run, e.g., adequate staffing, setting and managing expectations, facilitating streamlined and  
 32 personalized communication between physicians, staff and patients might all be negotiated for in a  
 33 strong economic environment, which could have the twofold benefit of improving patient  
 34 satisfaction and improving working conditions in the future. CLRPD identified study,  
 35 communication, and messaging as primary roles of the AMA in such a scenario. It would be  
 36 essential to understand the drivers of the poor perception of quality of care and communicate those  
 37 to physician groups as bases for negotiations. Additionally, identifying and sharing practices that  
 38 lead to improved patient satisfaction could help unions and other physicians engaged in

1 negotiations to self-assess and pinpoint potential points of action that have been proven to improve  
2 the patient experience. On a high level, the AMA's most valuable roles in such an environment  
3 would be to help physicians understand the patient experience, identify solutions that have been  
4 shown to improve those experiences, and communicate those solutions to aid in collective  
5 bargaining during a time when physicians would be expected to be in a stronger position to make  
6 appreciable gains through negotiation.

### 7 8 **Scenario 2 – Strong Economy & Positive Patient Perception of Quality of Care**

9 The Council noted that when organizations hit weak economic times, physicians are often overseen  
10 and restricted in greater ways. Health systems with strong finances, however, tend to allow  
11 physicians greater autonomy. Autonomy, raises, and improved working conditions were identified  
12 as the primary objectives in Scenario 2. If a health system is in a strong financial situation, and  
13 patients are satisfied with the quality of care they receive, physicians will be in the strongest  
14 position possible to demonstrate their successes and leverage those successes into personal gains  
15 and health system improvements that acknowledge and reward their expertise and achievements. In  
16 such a scenario, physicians in negotiation would likely work to demonstrate the positive outcomes  
17 of their work and use those data points to leverage their employers to make decisions that increase  
18 patient and physician satisfaction. The AMA-RAND study, "Factors Affecting Physician  
19 Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health  
20 Policy," noted that drivers of physician satisfaction include providing high-quality care or working  
21 at practices that facilitate the delivery of such care; income stability; payment arrangements that  
22 were perceived as fair, transparent, and aligned with good patient care; and reducing the  
23 cumulative burden of rules and regulations.<sup>14</sup> The AMA's work on physician satisfaction and  
24 practice sustainability could prove a major asset in such a scenario by providing data points to both  
25 physicians and health systems to demonstrate how satisfied physicians improve patient care and  
26 perception of care, the hidden costs of physician burnout, and the value of system and working  
27 condition improvements. It was also noted that in recent times, physicians often see pay reductions  
28 and pay increases are much more infrequent. In a scenario when measurables demonstrate high  
29 patient satisfaction, and the overall economy is strong, physicians would be in a strong position to  
30 collectively bargain for pay increases.

### 31 32 **Scenario 3 – Weak Economy & Negative Perception of Patient Care**

33 The converse of Scenario 2, this scenario imagined an environment in which the economy is weak,  
34 and patients have a poor perception of the quality of care they receive. In such a scenario, it was  
35 noted that everyone would be struggling, i.e., patients, physicians, and employers. This could be  
36 described as a "stop the bleeding" scenario in which negotiations would focus on preventing the  
37 weakening of the position of physicians. Among the focal points the Council identified as  
38 particularly significant in such a scenario were scope of practice and burnout. Health systems in  
39 weak financial situations will look for opportunities to reduce costs, which may include increasing  
40 the use of non-physician providers. It would be essential in such a scenario for physician unions  
41 and physician negotiators to push back against scope creep through collective bargaining. In health  
42 systems where patient care was already being delivered by mid-level providers, poorly perceived  
43 quality of care could act as an argument against scope creep. Conversely, health systems in which  
44 patient care was predominantly being delivered by physicians may attempt to leverage patient  
45 dissatisfaction to push for increased utilization of mid-level providers. Physicians would need data  
46 demonstrating the true effects of scope creep as it relates to both cost and quality. Other tendencies  
47 in such an environment would likely be to push physicians, residents and fellows into working  
48 longer hours, shorter and higher quantities of patient visits, and cost cutting measures, all factors  
49 likely to lead to even further reduced quality of care, poorer quality of life and worse educational  
50 environments for physicians in training, and increased burnout. The AMA's work on burnout could

1 be of value in this environment, providing support to struggling physicians and demonstrating to  
2 employers the mechanisms to and the value of reducing burnout.

#### 3 4 **Scenario 4 – Weak Economy & Positive Patient Perception of Quality of Care**

5 The Council noted that in this scenario, most of the issues related to a poor economy would still be  
6 relevant, as employers in a weak economy would still likely attempt to cut costs and get more for  
7 less. In theory, physicians in this scenario should be better positioned to negotiate against cost-  
8 cutting measures such as scope creep, as high patient perception of quality of care should be a  
9 focus of collective bargaining and a strong argument against such measures. However, several  
10 complicating scenarios were noted, including the possibility that in such an environment,  
11 employers may be more willing to take risks in care delivery, viewing the positive patient  
12 perception of quality as a backstop against possible declines. Additionally, the Council noted the  
13 distinction between patient perception of quality and quality care itself, and that some patients  
14 receiving direct care from mid-level providers may have a higher perception of the quality of care  
15 they receive (for instance, if mid-level providers spend more time with their patients than  
16 physicians can). It was also noted that by replacing one physician with two mid-level providers,  
17 health systems could charge more, thereby increasing revenue at the expense of both physicians  
18 and quality of care. Still, in an environment in which patient perception of quality is positive, the  
19 AMA could examine the causes of that positive perception, identify best practices to reduce costs  
20 while preserving quality of care, and communicate those best practices to health systems and  
21 physicians.

#### 22 23 **Scenario 5 – Negative Working Conditions & An Acceptable View of Work Stoppages**

24 A complicating scenario related to physician unionization is the idea of work stoppages and the  
25 potential impacts of work stoppages on the health of patients. Section 1.2.10 in the Code of  
26 Medical Ethics states that physicians who participate in advocacy should “[a]void using disruptive  
27 means to press for reform. Strikes and other collection actions may reduce access to care, eliminate  
28 or delay needed care, and interfere with continuity of care and should not be used as a bargaining  
29 tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of  
30 calling attention to the need for changes in patient care.”<sup>15</sup> As unionization becomes more prevalent  
31 among physicians, unions will explore all possible tactics to increase leverage during collective  
32 bargaining. In January 2024, thousands of junior physicians in the United Kingdom (UK) engaged  
33 in a six-day strike over low wages leading to the postponement of more than 110,000  
34 appointments.<sup>16</sup> Senior doctors and other medical professionals were available to cover emergency  
35 services, critical care, and maternity services. This represented the longest strike in the history of  
36 the UK’s National Health Service (NHS).<sup>17</sup> The NHS national medical director said it would take  
37 hospitals “weeks and months” to recover from the stoppage.<sup>18</sup> Despite the obvious impacts  
38 physician work stoppages have on health care delivery, it is impossible to ignore the possibility that  
39 they may become a reality in the United States in an environment with a more highly unionized  
40 physician workforce. There are obvious parallels to be drawn between junior physicians in the  
41 United Kingdom and residents and fellows in the United States, who earn significantly less than  
42 their more senior colleagues, while working potentially more hours per week.

43  
44 Scenario 5 imagines a situation in which physician working conditions are poor and the  
45 consequences of work stoppages are viewed as an acceptable tactic in collective bargaining. While  
46 what is “acceptable” will always vary between groups, individuals, organizations, etc., this scenario  
47 is one where the opportunity for work stoppage or the threat of work stoppage and other forms of  
48 collective action is most realistic. The Council noted that in such a scenario, it would be essential  
49 for the AMA to provide a backstop of support demonstrating the moral and ethical duty of  
50 physicians to act in the best interest of patient care and communicate that work stoppages are not  
51 and should not be about money, but about physicians doing what they can to fulfill their duty to

1 their oath and to their patients. Members also noted that work stoppages can take a variety of  
2 forms, such as—like in the case of the NHS strike—predetermined and preannounced periods of  
3 unavailability by physicians in an effort to highlight system inadequacies (rather than, for instance,  
4 a strike of indeterminable duration) and that this types of collective action could more easily be  
5 viewed as action toward improving patient care and not harming it. On a high level, this scenario  
6 made apparent the likelihood of a future in which physician work stoppages of some form, and the  
7 downstream consequences of those stoppages, would become a reality, and the AMA’s most  
8 effective means of supporting physicians in such an environment will need to be considered,  
9 particularly as it relates to potential conflict with AMA policy and the Code of Medical Ethics. In  
10 response to policy adopted at the 2023 Annual Meeting of the House of Delegates (H-405.946,  
11 “Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization)  
12 the Council on Ethical and Judicial Affairs (CEJA) is developing a report for the 2024 Interim  
13 Meeting “to review the advisory restricting collective action in section 1.2.10 of its Code of  
14 Medical Ethics to allow for more flexibility on the part of physicians who have exhausted other  
15 non-disruptive methods for reform.” Current AMA policy on unions and collective bargaining has  
16 been appended to this memo.

17

### 18 **Scenario 6 – Positive Working Conditions & An Acceptable View of Work Stoppages**

19 The Council viewed Scenario 6 as an ideal time for the AMA to engage in organizing, preparation  
20 and analysis. While work stoppages in such a scenario would be less likely to be necessary, laying  
21 the groundwork to preserve desirable working conditions and keeping them heading in the right  
22 direction can occur during this time, as well as can the preparation for a future in which work  
23 stoppages may become a necessary/useful tool. Such a scenario would present the AMA with an  
24 opportunity to analyze progress that has been made and by what mechanisms and communicate  
25 those successes to other physician groups attempting to improve their own conditions. This  
26 scenario could also present an opportunity to analyze the overall status of unionization and  
27 collective bargaining and successful organizational structures and negotiation tactics with the hope  
28 of working toward scenarios where improvements continue without the need for work stoppages or  
29 the threats of work stoppages. As one member put it, this scenario is “time to get to work.”

30

### 31 **Scenario 7 – Negative Working Conditions & An Unacceptable View of Work Stoppages**

32 In Scenario 7 it becomes essential to identify solutions and collective bargaining strategies to push  
33 toward improved conditions without the threat of work stoppage. If the public and/or physicians  
34 themselves determine that any level of disruption to care delivery cannot occur, unions will  
35 necessarily find themselves in a weakened position for negotiation. The AMA could aid physicians  
36 in such a scenario by identifying, or proliferating already identified, successes that have occurred  
37 without the need for work stoppages. The Council also noted that in a scenario in which working  
38 conditions are deteriorating, but work stoppages are not an option, physicians may simply choose  
39 to quit, leading to a worsening physician shortage and poorer access to quality care. The Council  
40 noted that this scenario space is not unlike what physicians encountered during the worst of the  
41 COVID-19 pandemic, during which working conditions were as bad as they could have been, but  
42 no physician group would have been willing to threaten a strike even if they were already in a  
43 union or looking to join one. That situation led to early retirements and physicians considering  
44 alternative career paths, along with rises in physician mental health issues and suicides. Non-  
45 compete clauses also present a significant challenge in such an environment, as physicians dealing  
46 with declining working conditions who have signed such clauses cannot simply change systems but  
47 must either relocate or remain and suffer. Providing support and resources to physicians in  
48 challenging situations represents another area where the AMA could make a significant impact.

**Scenario 8 – Positive Working Conditions & An Unacceptable View of Work Stoppages**

Not unlike Scenario 6, unions in Scenario 8 would likely be focused on attempting to “lock in” the progress being made. Such a scenario may present opportunities to establish metrics to better quantify improvements in working conditions. The Council observed that more opportunities may exist for medical associations including the AMA to engage in benchmarking and best practice research and sharing. In this scenario, techniques other than the threat of work stoppages have clearly been effective, evidenced by improving working conditions. However, it was noted that it is unlikely that conditions would be improving among all physicians and across all employers, so this would be a time to work through unions and organizations to identify and implement best practices as widely as possible and to include experienced physicians, residents, and fellows. It was also noted that both the overall quality of working conditions, as well as the trend in working conditions (i.e., improving or declining) are relevant; good working conditions can decline just as poor working conditions can improve, making the establishment of benchmarks even more useful in allowing physicians and systems to assess the overall state of conditions as well as making changes easier to assess.

**DISCUSSION**

As part of its deliberations, the Council considered not only how the needs of physicians and physicians in training will change in an increasingly employed and unionized workforce, but how those changes in workforce trends would impact the AMA, its membership and its mission, i.e., what does unionization mean for the AMA and other medical associations? The goals and capabilities of these organizations remain consistent—regardless of how physicians work and organize—and include advocating for physicians and trainees, communicating on their behalf, convening groups to facilitate collaboration, providing timely educational resources, and identifying and sharing best practices to help physicians achieve their practice and career goals. Organized medicine provides value to all physicians, whether or not they join a specific association or a union. As has been observed with the move away from private practice and towards employment, the challenges physicians and trainees face as practice models evolve do not become apparent immediately, but often do so suddenly and urgently; organizations working on their behalf must remain nimble and responsive to their evolving needs to provide effective support and membership value. On the rapidly developing issue of physician collective bargaining and unionization, it will be essential to monitor changes in the space, maintain awareness of difficulties and successes as they occur, and identify the most effective roles of the AMA in the context of the changing workforce and macro environment.

The Council believes that an open forum at an upcoming HOD meeting through which physicians, residents and fellows who have encountered unionization directly could share their experiences would be extremely useful in expanding the Association’s understanding of the impacts such efforts have on grassroots members and facilitate discussion and idea sharing among those currently involved in these initiatives. It will also be essential for stakeholders throughout AMA membership and staff who are either involved in or likely to be impacted by the growing trend of unionization to find opportunities for collaboration to maximize understanding and impact.

This analysis assumes a future in which a greater proportion of physicians and physicians in training choose employed practice models and join unions. While the exercise focused on specific factors in the overall environment to assess how the needs of physicians and physicians in training would be impacted, and how the AMA could aid negotiating physicians in such environments, the needs and wishes of physicians are relatively consistent regardless of work setting and include providing high-quality care; working environments that facilitate high-quality care; stable, fair, and transparent pay arrangements; and reduced regulatory burdens. However, the mechanisms available

1 to work toward these goals will change along with environmental factors and changing models of  
2 care delivery and organizational structures. The Council will continue to monitor this evolving  
3 area.

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**Appendix 1 – Committee of Interns and Residents Unionized Hospitals**

<b>CALIFORNIA</b>		
Alameda Health System / Highland Hospital	Oakland	CA
California Hospital Medical Center	Los Angeles	CA
Harbor-UCLA Medical Center	Torrance	CA
Kern Medical Center	Bakersfield	CA
LAC+USC Medical Center	Los Angeles	CA
Santa Clara Valley Medical Center	San Jose	CA
St. Mary Medical Center – Long Beach	Long Beach	CA
St. Mary’s Medical Center – San Francisco	San Francisco	CA
Sutter Santa Rosa Regional Hospital	Santa Rosa	CA
UC-Irvine Medical Center	Orange	CA
UCSF Medical Center	San Francisco	CA
UCSF Benioff Children’s Hospital	Oakland	CA
Valley Consortium for Medical Education	Modesto	CA
Zuckerburg San Francisco General (formerly SFGH)	San Francisco	CA
<b>FLORIDA</b>		
Jackson Memorial Hospital	Miami	FL
<b>Illinois</b>		
University of Illinois-Chicago	Chicago	IL
<b>MASSACHUSETTS</b>		
Boston Medical Center	Boston	MA
Cambridge Health Alliance	Cambridge	MA
<b>NEW JERSEY</b>		
Bergen Regional Medical Center	Paramus	NJ
Christ Hospital	Jersey City	NJ
Hoboken University Medical Center	Hoboken	NJ
Jersey City Medical Center	Jersey City	NJ
Rowan University SOM (Kennedy/Lourdes)	Stratford	NJ
Rutgers University – NJMS	Newark	NJ
Rutgers University – RWJMS	New Brunswick	NJ
St. Michael’s Medical Center	Newark	NJ
<b>NEW MEXICO</b>		
University of New Mexico	Albuquerque	NM
<b>NEW YORK</b>		
Bellevue Hospital Center	New York	NY
Bronx Lebanon Hospital Center	Bronx	NY

Brookdale Medical Center	Brooklyn	NY
Brooklyn Hospital Center	Brooklyn	NY
Coney Island Hospital	Brooklyn	NY
Elmhurst Hospital Center	Queens	NY
Flushing Hospital Medical Center	Queens	NY
Harlem Hospital Center	Manhattan	NY
Institute for Family Health	Manhattan	NY
Interfaith Medical Center	Brooklyn	NY
Jacobi Medical Center	Bronx	NY
Jamaica Hospital Medical Center	Queens	NY
Kings County Hospital Center	Brooklyn	NY
Kingsbrook Jewish Medical Center	Brooklyn	NY
Lincoln Medical & Mental Health Center	Bronx	NY
Maimonides Medical Center	Brooklyn	NY
Metropolitan Hospital Center	Manhattan	NY
Montefiore Medical Center North	Bronx	NY
New York Methodist Hospital	Brooklyn	NY
St. Barnabas Hospital	Bronx	NY
St. John's Episcopal Hospital	Queens	NY
St. Luke's-Roosevelt Hospital	Manhattan	NY
Westchester County Health Care	Valhalla	NY
Woodhull Hospital Center	Brooklyn	NY
Wyckoff Heights Medical Center	Brooklyn	NY
<b>Vermont</b>		
University of Vermont	Burlington	VT
<b>WASHINGTON, DC</b>		
Children's National Medical Center	Washington	DC
Howard University Hospital	Washington	DC
St. Elizabeths Hospital	Washington	DC



## **Appendix 2 – AMA Policies Related to Unionization and Collective Bargaining**

### **Code of Medical Ethics Opinion 1.2.10 Political Action by Physicians**

Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However, they have a responsibility to do so in ways that are not disruptive to patient care.

Physicians who participate in advocacy activities should:

- (a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.
- (b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.
- (c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians' primary and overriding commitment to patients.
- (d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

### **Investigation into Residents, Fellows and Physician Unions D-383.977**

Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment.

#### Implementation

Our AMA continues to study the risks and benefits of collective bargaining for physicians and physicians-in-training and works closely with state and national medical specialty societies interested in the issues raised in this Resolution.

Our AMA developed an advocacy issue brief that studies the risks and benefits of collective bargaining for physicians and physicians-in-training and shared this document with all state and national medical specialty societies. Our AMA will continue to work closely with state and national medical specialty societies interested in the issues raised in this Resolution.

### **Employee Associations and Collective Bargaining for Physicians D-383.981**

Our AMA will study and report back on physician unionization in the United States.

### **Collective Bargaining: Antitrust Immunity D-383.983**

Our AMA will: (1) continue to pursue an antitrust advocacy strategy, in collaboration with the medical specialty stakeholders in the Antitrust Steering Committee, to urge the Department of Justice and Federal Trade Commission to amend the "Statements of Antitrust Enforcement Policy in Health Care" (or tacitly approve expansion of the Statements) and adopt new policy statements

regarding market concentration that are consistent with AMA policy; and (2) execute a federal legislative strategy.

### **Collective Bargaining and the Definition of Supervisors D-383.988**

Our AMA will support legislative efforts by other organizations and entities that would overturn the Supreme Court's ruling in *National Labor Relations Board v. Kentucky River Community Care, Inc., et al.*

#### Update

2022: In *Piedmont Health Services, Inc. and Piedmont Health Services Medical Providers United*, Case No. 10-RC-286648, Region 10 of the National Labor Relations Board (Region) issued a Decision and Direction of Election (DDE) in which it held that physicians are not supervisors under the National Labor Relations Act (the Act) simply by virtue of their position in the healthcare institution.

This DDE is notable, as it confirms that physicians will not automatically be considered supervisors under the Act and may seek union representation. Indeed, Piedmont's physicians and providers ultimately voted in favor of union representation. Healthcare employers should consider reviewing their physicians' job descriptions and job duties to determine whether they potentially can be considered supervisors under the Act.

### **Antitrust Relief as a Priority of the AMA H-380.987**

Our AMA will continue its aggressive efforts to achieve appropriate negotiations rights and opportunities and necessary antitrust relief for physicians, by whatever means. Achieving this important goal will remain a top priority for the Association.

### **Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988**

Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare.

### **Antitrust Relief for Physicians Through Federal Legislation H-383.990**

Our AMA:

(1) encourages state medical associations and national medical specialty societies to support federal antitrust reform bills, such as H.R. 1409, as originally introduced in the 112th Congress, and consider sending in letters of support for such antitrust reform legislation to their respective Congressional delegations and select Congressional leaders;

(2) supports the intent of antitrust reform bills, such as H.R. 1409, as originally introduced in the 112th Congress, that put access to quality patient medical care and patient rights ahead of health insurer profits;

(3) continues to advocate for the principles that support that any health care professional, including a physician or a physician group, which is engaged in negotiations with a health plan regarding the terms of any contract under which the professional provides health care items or services for which benefits are provided shall, in connections with such negotiations, be exempt from federal antitrust laws;

(4) continues to advocate for the concepts and limitations incorporated in H.R. 1409, as originally introduced in the 112th Congress, including: no new rights for collective cessation of service to patients, no amendments to the National Labor Relations Act; and no application of H.R. 1409, as originally introduced in the 112th Congress, to the Medicare program under Title XVIII, the Medicaid program under Title IX, the SCHIP program under Title XXI of the Social Security Act; or programs related to medical services for members of the uniformed service, veterans, federal employees health benefit program or Indian Health Services;

(5) will send a letter of support to Congress of the principles contained in H.R. 1409 as originally introduced in the 112th Congress; and

(6) will work with members of Congress to promote antitrust reform in light of Accountable Care Organization (ACO) development.

#### **Antitrust Relief H-383.992**

Our AMA will: (1) redouble efforts to make physician antitrust relief a top legislative priority, providing the necessary foundation for fair contract negotiations designed to preserve clinical autonomy and patient interest and to redirect medical decision making to patients and physicians; and (2) affirm its commitment to undertake all appropriate efforts to seek legislative and regulatory reform of state and federal law, including federal antitrust law, to enable physicians to negotiate effectively with health insurers.

#### **Resident Physicians, Unions and Organized Labor H-383.998**

Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients.

#### **Collective Bargaining for Physicians H-385.946**

The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation.

#### **Physician Collective Bargaining H-385.976**

Our AMA's present view on the issue of physician collective negotiation is as follows:

(1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians.

(2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature.

(3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively.

(4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.

(5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.

**Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization H-405.946**

1. Our American Medical Association will: (1) reevaluate the various efforts to achieve collective actions and/or unionization for physicians nationally; and (2) request CEJA to review the advisory restricting collective action in section 1.2.10 of its Code of Medical Ethics to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-24

Subject: Health System Consolidation

Presented by: Sheila Rege, MD, Chair

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1 At the 2023 Annual Meeting, the House of Delegates adopted Policy D-160.907, Health System  
2 Consolidation, which directed the American Medical Association (AMA) to: 1) assess and report  
3 annually on nationwide health system and hospital consolidation, as well as payer consolidation, to  
4 assist policymakers and the federal government; 2) that the annual report on nationwide hospital  
5 consolidation be modeled after the “Competition in Health Insurance: A comprehensive study of  
6 U.S. Markets” in its comprehensiveness to include for example data and analyses as: a) a review of  
7 the current level of hospital and/or health system consolidation at the level of all metropolitan  
8 statistical areas, state, and national markets; b) a list of all mergers and acquisition transactions  
9 valued above a set threshold amount resulting in hospital and/or health system consolidation;  
10 c) analyses of how each transaction has changed or is expected to change the level of competition  
11 in the affected service and geographic markets; and d) analyses of how health care costs and price  
12 have changed in affected markets after large consolidation transaction has taken place; 3) that the  
13 AMA report the initial findings of this study to the House of Delegates by the 2024 Annual  
14 Meeting; and 4) that the AMA report the findings of this study to its members and stakeholders,  
15 including policymakers and legislators, to inform future health care policy.

16  
17 The Board of Trustees assigned only the third Resolve clause of Policy D-160.907 to the Council  
18 for a report back at the 2024 Annual Meeting. The balance of the directive was assigned to AMA  
19 staff to implement (i.e., the AMA’s Division of Economic and Health Policy Research). Data were  
20 used primarily from the American Hospital Association (AHA) to assess competition in hospital  
21 markets. As directed by Policy D-160.907, the requested analysis was modeled after the AMA’s  
22 Competition in Health Insurance study.

23  
24 This informational Council report serves as notice to the House of Delegates regarding the report  
25 from the AMA’s Division of Economic and Health Policy Research. Here we share topline findings  
26 from the Policy Research Perspective titled: “[Competition in Hospital Markets, 2013-2021](#)” and  
27 encourage interested members to reference the full analysis for a more robust discussion of the  
28 findings.

29  
30 **BACKGROUND**

31  
32 The economic study was conducted using the AHA’s 2013, 2017, and 2021 Annual Survey  
33 Databases. These databases were used to calculate shares and concentration levels in markets  
34 across the United States. The Herfindahl-Hirschman Index (HHI) indicates the level of market  
35 concentration and was calculated for each Metropolitan Statistical Area (MSA). The HHI is  
36 calculated as a sum of the squared market shares for all firms found within a market. A higher HHI  
37 indicates higher concentration. For example, if a market consisted of four firms and each firm held  
38 a 25 percent share, the HHI for that market would be 2,500:

39  
40 
$$25^2 + 25^2 + 25^2 + 25^2 = 2,500$$

1 If the number of firms in a market increased, the HHI would generally decrease, and vice versa.

2  
3 Appendices A1 and A2 show that in the majority of MSA-level markets, hospitals (or systems)  
4 have large market shares. In 97 percent of markets, at least one hospital (system) had a market  
5 share of 30 percent or greater in 2021, and 77 percent of markets had one hospital (system) with a  
6 share of 50 percent or more in 2021 – up from 70 percent or more in 2013. In 43 percent of  
7 markets, a single hospital (system) had a market share of 70 percent or more in 2021 – an increase  
8 from 37 percent in 2013. The fraction of hospitals that are a part of a system has also been  
9 increasing over time, increasing from 70 percent in 2013 to 76 percent in 2017 to 78 percent in  
10 2021.

11  
12 Appendix B shows that, on average, hospital markets are highly concentrated and market  
13 concentration has been increasing over time. Virtually all hospital markets (99 percent) are highly  
14 concentrated.

15  
16 A complete list of the two largest hospitals' (or systems') market shares and the HHIs by MSA can  
17 be found in the full analysis.

#### 18 19 AMA POLICY

20  
21 The AMA has several policies, and the Council has presented several recent reports to the House of  
22 Delegates on hospital consolidation and health care mergers and acquisitions.

23  
24 CMS Report 8-A-23, Impact of Integration and Consolidation on Patients and Physicians,  
25 recommended that the AMA: 1) continue to monitor the impact of hospital-physician practice and  
26 hospital-hospital mergers and acquisitions on health care prices and spending, patient access to  
27 care, potential changes in patient quality outcomes, and physician wages and labor; 2) continue to  
28 monitor how provider mix may change following mergers and acquisitions and how non-compete  
29 clauses may impact patients and physicians; 3) broadly support efforts to collect relevant  
30 information regarding hospital-physician practice and hospital-hospital mergers and acquisitions in  
31 states or regions that may fall below the Federal Trade Commission (FTC)/Department of Justice  
32 review threshold; 4) encourage state and local medical associations, state specialty societies, and  
33 physicians to contact their state's attorney general with concerns of anticompetitive behavior; and  
34 encourage physicians to share their experiences with mergers and acquisitions, such as those  
35 between hospitals and/or those between hospitals and physician practices, with the FTC via their  
36 online submission form.

37  
38 CMS 2-I-22, Corporate Practice of Medicine, recommended that the AMA: 1) acknowledge that  
39 the corporate practice of medicine has the potential to erode the patient-physician relationship;  
40 2) acknowledge that the corporate practice of medicine may create a conflict of interest between  
41 profit and best practices in residency and fellowship training; and 3) amend Policy H-160.891 by  
42 addition of two new clauses stating that each individual physician should have the ultimate  
43 decision for medical judgment in patient care and medical care processes, including the supervision  
44 of non-physician practitioners and physicians should retain primary and final responsibility for  
45 structured medical education inclusive of undergraduate and graduate medical education including  
46 the structure of the program, program curriculum, selection of faculty and trainees, as well as  
47 educational and disciplinary issues related to these programs.

48  
49 CMS 3-I-22, Health System Consolidation, was an informational report and the first in a series the  
50 Council has on this and related topics. CMS 3-I-22 shared background information on vertical and  
51 horizontal mergers and acquisitions and highlighted notable transactions from 2020. The Council

1 will continue its work on this issue and provide additional reports for the consideration of the  
2 House of Delegates when appropriate.

3  
4 Policy D-160.907, established by the adoption of Resolution 727-A-23 as amended, states that the  
5 AMA will: assess and report annually on nationwide health system and hospital consolidation as  
6 well as payer consolidation, to assist policymakers and the federal government; model this report  
7 on nationwide hospital consolidation after the “Competition in Health Insurance” study in its  
8 comprehensiveness to include for example, data and analyses such as: a) a review of the current  
9 level of hospital and/or health system consolidation at the level of all metropolitan statistical areas,  
10 state, and national markets; a list of all mergers and acquisition transactions valued above a set  
11 threshold amount resulting in hospital and/or health system consolidation; analyses of how each  
12 transaction has changed or is expected to change the level of competition in the affected service  
13 and geographic markets; analyses of how health care costs and prices have changed in affected  
14 markets after a large consolidation transaction has taken place.

15  
16 Policy H-160.884 states that the AMA opposes not-for-profit firm immunity from FTC competition  
17 policy enforcement in the health care sector, supports appropriate transaction value thresholds,  
18 including cumulative transaction values, for merger reporting in health care sectors to ensure that  
19 vertical acquisitions in health care do not evade antitrust scrutiny, and supports health care-specific  
20 advocacy efforts that will strengthen antitrust enforcement in the health care sector through  
21 multiple mechanisms.

22  
23 Policy H-215.960 states that the AMA: affirms that a) health care entity mergers should be  
24 examined individually, taking into account case-specific variables of market power and patient  
25 needs; b) the AMA strongly supports and encourages competition in all health care markets; c) the  
26 AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on  
27 patients and providers; and d) antitrust relief for physicians remains a top AMA priority. The AMA  
28 will continue to support actions that promote competition and choice, including (a) eliminating  
29 state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing  
30 administrative burdens that make it difficult for physician practices to compete; and (d) achieving  
31 meaningful price transparency; and (3) will work with interested state medical associations to  
32 monitor hospital markets, including rural, state, and regional markets, and review the impact of  
33 horizontal and vertical health system integration on patients, physicians, and hospital prices.

34  
35 Policy H-215.969 states that it is the policy of the AMA that, in the event of a hospital merger,  
36 acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be  
37 established to resolve at least the following issues: a) medical staff representation on the board of  
38 directors; b) clinical services to be offered by the institutions; c) process for approving and  
39 amending medical staff bylaws; d) selection of the medical staff officers, medical executive  
40 committee, and clinical department chairs; e) credentialing and recredentialing of physicians and  
41 limited licensed providers; f) quality improvement; g) utilization and peer review activities;  
42 h) presence of exclusive contracts for physician services and their impact on physicians’ clinical  
43 privileges; i) conflict resolution mechanisms; j) the role, if any, of medical directors and physicians  
44 in joint ventures; k) control of medical staff funds; l) successor-in-interest rights; m) that the  
45 medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals;  
46 and that the AMA will work to ensure, through appropriate state oversight agencies, that where  
47 hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the  
48 merging entity shall be responsible for ensuring continuing community access to these services.

49  
50 Policy D-215.984 states that the AMA will study nationwide health system and hospital  
51 consolidation in order to assist policymakers and the federal government in assessing health care

1 consolidation for the benefit of patients and physicians who face an existential threat from health  
2 care consolidation and regularly review and report back on these issues to keep the House of  
3 Delegates apprised on relevant changes that may impact the practice of medicine, with the first  
4 report no later than the 2023 Annual meeting.

5  
6 Policy D-225.995 states that the AMA will continue to monitor and report on current numbers of  
7 mergers and break-ups of mergers of hospitals in this country. Policy D-383.980 states that the  
8 AMA will study the potential effects of monopolistic activity by health care entities that may have  
9 a majority of market share in a region on the patient-doctor relationship and develop an action plan  
10 for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to  
11 protect physician practices which are confronted with potentially monopolistic activity by health  
12 care entities.

13  
14 DISCUSSION

15  
16 As expected, the majority of markets in the United States are characterized by hospitals with large  
17 market shares. Virtually all hospital markets are highly concentrated, and, on average, this  
18 concentration has been increasing over time.

19  
20 REFERENCES

<sup>1</sup>Guardado, José R., PhD. AMA Policy Research Perspectives. *Competition in Hospital Markets, 2013-2021*.  
American Medical Association. 2024.

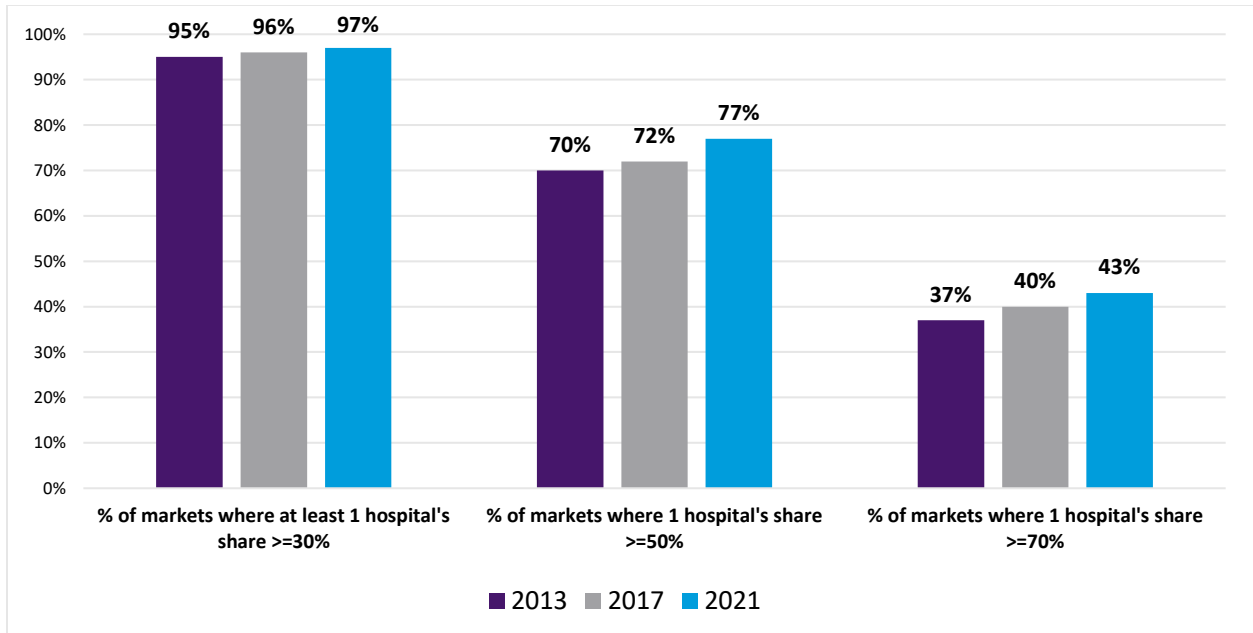


**Appendix A1**  
**Hospital Market Shares and System Membership, 2013-2021**

<b>Variable</b>	<b>2013</b>	<b>2017</b>	<b>2021</b>
% of Markets where at least 1 hospital's share >=30%	95%	96%	97%
% of Markets where 1 hospital's share >=50%	70%	72%	77%
% of Markets where 1 hospital's share >=70%	37%	40%	43%
% of Hospitals that are members of systems	70%	76%	78%
Number of hospitals	1946	2021	2002
Number of systems	276	273	268
Number of markets	363	387	389

1. Source: Author's calculations of data from the 2013, 2017 and 2021 American Hospital Association Annual Surveys.
2. This paper defines geographic markets as metropolitan statistical areas (MSAs). For MSAs that are very large (e.g. New York, Chicago), markets are defined as smaller parts of those MSAs called metropolitan divisions.
3. A "hospital" in the first three rows of this Exhibit relating to market shares can either refer to a hospital or a hospital system. Some hospitals belong to systems, while others do not. If there is more than 1 one hospital belonging to the same system in an MSA, the admissions are aggregated up to the system level. Market shares are calculated from system-wide admissions in an MSA. In those cases, the "hospital's" market share here refers to the system's share.

## Appendix A2 Hospital Market Shares, 2013-2021



1. Source: Author's calculations of data from the 2013, 2017 and 2021 American Hospital Association Annual Surveys.
2. This paper defines geographic markets as metropolitan statistical areas (MSAs). For MSAs that are very large (e.g. New York, Chicago), markets are defined as smaller parts of those MSAs called metropolitan divisions.
3. A "hospital" in the first three rows of this Exhibit relating to market shares can either refer to a hospital or a hospital system. Some hospitals belong to systems, while others do not. If there is more than one hospital belonging to the same system in an MSA, the admissions are aggregated up to the system level. Market shares are calculated from system-wide admissions in an MSA. In those cases, the "hospital's" market share here refers to the system's share.

**Appendix B**  
**Hospital Market Concentration, 2013-2021**

<b>Variable</b>	<b>2013</b>	<b>2017</b>	<b>2021</b>
Weighted average HHI	3722	3853	4062
% of Markets that are highly concentrated	97%	98%	99%
Number of markets	363	387	389

1. Source: Author's calculations of data from the 2013, 2017 and 2021 American Hospital Association Annual Surveys.
2. This paper defines geographic markets as metropolitan statistical areas (MSAs). For MSAs that are very large (e.g. New York, Chicago), markets are defined as smaller parts of those MSAs called metropolitan divisions.
3. HHI is the Herfindahl-Hirschmann Index, which is a measure of market concentration. The average HHI is weighted by metropolitan-area population.

## **Relevant AMA Policy Health System Consolidation**

### **Health System Consolidation, D-160.907**

1. Our American Medical Association (AMA) will assess and report annually on nationwide health system and hospital consolidation, as well as payer consolidation, to assist policymakers and the federal government.
2. Our AMA annual report on nationwide hospital consolidation will be modeled after the “Competition in Health Insurance: A Comprehensive Study of U.S. Markets” in its comprehensiveness to include for example data and analyses as:
  - a) A review of the current level of hospital and/or health system consolidation at the level of all metropolitan statistical areas, state, and national markets;
  - b) A list of all mergers and acquisition transactions valued above a set threshold amount resulting in hospital and/or health system consolidation;
  - c) Analyses of how each transaction has changed or is expected to change the level of competition in the affected service and geographic markets;
  - d) Analyses of health care costs and prices have changed in affected markets after a large consolidation transaction has taken place.
3. Our AMA will report the initial findings of this study to the House of Delegates by Annual 2024.
4. Our AMA will report the findings of this study to its members and stakeholders, including policymakers and legislators, to inform future health care policy.  
(Res. 727, A-23)

### **Strengthening Efforts Against Horizontal & Vertical Consolidation, H-160.884**

1. Our AMA opposes not-for-profit firm immunity from FTC competition policy enforcement in the health care sector.
2. Our AMA supports appropriate transaction value thresholds, including cumulative transaction values, for merger reporting in health care sectors to ensure that vertical acquisitions in health care do not evade antitrust scrutiny.
3. Our AMA supports health care-specific advocacy efforts that will strengthen antitrust enforcement in the health care sector through multiple mechanisms.  
(Res. 813, I-23)

### **Hospital Consolidation, H-215.960**

Our AMA: (1) affirms that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority; (2) will continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency; and (3) will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians, and hospital prices.  
(CMS Rep. 07, A-19; Reaffirmation, I-22)

### **Hospital Merger Study, H-215.969**

1. It is the policy of the AMA that, in the event of a hospital merger, acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues:
  - (A) medical staff representation on the board of directors;

- (B) clinical services to be offered by the institutions;
  - (C) process for approving and amending medical staff bylaws;
  - (D) selection of the medical staff officers, medical executive committee, and clinical department chairs;
  - (E) credentialing and recredentialing of physicians and limited licensed providers;
  - (F) quality improvement;
  - (G) utilization and peer review activities;
  - (H) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges;
  - (I) conflict resolution mechanisms;
  - (J) the role, if any, of medical directors and physicians in joint ventures;
  - (K) control of medical staff funds;
  - (L) successor-in-interest rights;
  - (M) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals; and
2. Our AMA will work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services.  
(CMS Rep. 4, I-01; Reaffirmed: CMS Rep. 7, A-11; Appended: Res. 3, I-13; Reaffirmed: CMS Rep. 07, A-19)

#### **Health System Consolidation, D-215.984**

Our AMA will: (1) study nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing health care consolidation for the benefit of patients and physicians who face an existential threat from health care consolidation; and (2) regularly review and report back on these issues to keep the House of Delegates apprised on relevant changes that may impact the practice of medicine, with the first report no later than the 2023 Annual meeting.  
(Res. 702, A-22)

#### **Hospital Merger Study, D-225.995**

Our AMA will: (1) urge its AMA Commissioners to the Joint Commission to seek the inclusion of a standard in The Joint Commission hospital accreditation program requiring a medical staff successor-in-interest standard in the hospital medical staff bylaws; (2) seek inclusion of medical staff bylaw successor-in-interest provisions in the Medicare Conditions of Participation and in the rules and regulations of other public and private hospital accreditation agencies; and (3) continue to monitor and report on current numbers of mergers and break-ups of mergers of hospitals in this country.  
(CMS Rep. 7, I-00; Modified: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20)

#### **Health Care Entity Consolidation, D-383.980**

Our AMA will (1) study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship; and (2) develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities. (BOT Rep. 8, I-15)

# REPORT OF THE SPEAKERS

Speakers' Report 2-A-24

Subject: Report of the Election Task Force 2

Presented by: Lisa Bohman Egbert, MD, Speaker; and John A. Armstrong, MD, Vice Speaker

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1 BACKGROUND

2

3 At the 2023 Interim Meeting, the Election Task Force 2 (ETF2) submitted Speakers' Report 3-I-23  
4 which included multiple recommendations, many of which were ultimately referred back. The  
5 ETF2 subsequently met February 10, 2024, to review these items and testimony heard at I-23. The  
6 task force will hold an open forum on Sunday, June 9, 2024, at 3:00 pm CT to gather additional  
7 feedback on these items and will then develop a report with final recommendations to be presented  
8 at Interim 2024. The topics of consideration listed on this report will be the basis for discussion at  
9 the open forum.

10

11 ITEMS FOR DISCUSSION

12

13 The ETF 2 noted that there was a general lack of clear definitions related to items surrounding  
14 AMA elections. Therefore, they developed the definitions in the Glossary shown below. In  
15 addition, the ETF 2 reviewed all items that were referred back for further consideration and  
16 suggested changes shown as additions and deletions and the rationale for these suggestions in the  
17 grid that follows. The ETF 2 asks that delegations review and make comments on the Glossary and  
18 Proposed Changes at the Open Forum.

19

20 The final topic for consideration at the open forum will be a consideration of endorsements. This  
21 will be an open topic and all input is encouraged.

22

23 **Glossary**

24

25 Active campaign window – period of time after the speaker's notice of the opening of active  
26 campaigning until the Election Session during the House of Delegates meeting at which elections  
27 are being held

28

29 Active campaigning – Outreach by candidates or their surrogate(s), including but not limited to  
30 members of their campaign team, to members of the House of Delegates with the goal of being  
31 elected by the AMA House of Delegates

32

33 Announced candidate – person who has indicated their intention to run for elected position;  
34 announcement can be made only by sending an electronic announcement card to the Speakers via  
35 the HOD office by email to [hod@ama-assn.org](mailto:hod@ama-assn.org)

36 Campaign manager(s) – person(s) identified by the candidate to the HOD Office as the person(s)  
37 responsible for running the campaign

- 1 Campaign team – campaign manager(s) and/or staff identified by the candidate to the HOD Office
- 2
- 3 Campaign-related – any content that includes reference to an announced candidate in the context of
- 4 their candidacy for an elected position within the AMA
- 5
- 6 Digital – relating to, using, or storing data or information in the form of digital signals; involving or
- 7 relating to the use of computer technology; this includes but is not limited to social media and
- 8 communication platforms
- 9
- 10 Elected position(s) – Council or Officer position within the AMA elected by the House of
- 11 Delegates of the AMA
- 12
- 13 Featured – identification of a candidate at an event by the host or organizer of the event including
- 14 but not limited to written or verbal announcement of the candidate or their candidacy

ETF 2 Proposed Language <i>(Proposed changes to current policy or items from ETF 2 I-23 report shown in red)</i>	Rationale
<p><i>Proposed changes to current policy:</i></p> <p>Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, <u>AMA</u>, the AMA Foundation, specialty societies, state and regional delegations <del>and health related causes that do not include any candidate identifier</del>. 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.</p>	<p>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.</p>
<p><i>New language referred at I-23 with proposed changes.</i></p> <p><del>Only a</del><u>A</u>n 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 <del>including members of campaign teams, delegations or caucuses, and "friends."</del> <u>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.</u></p>	<p>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.</p>

<b>ETF 2 Proposed Language</b> <i>(Proposed changes to current policy or items from ETF 2 I-23 report shown in red)</i>	<b>Rationale</b>
<p><i>Proposed changes to current policy:</i></p> <p><u>Printed and digital</u> <del>C</del>campaign materials may not be distributed <u>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.</u> The AMA Office of House of Delegates Affairs will not <del>longer</del> furnish a file containing the names and mailing addresses of members of the AMA-HOD. <del>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.</del></p>	<p>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.</p>
<p><i>Proposed changes to current policy:</i></p> <p><u>Active campaigning via mass outreach to delegates by candidates or on behalf of a candidate by any method is prohibited.</u> A reduction in the volume of campaign-related telephone calls and <u>personal</u> electronic communication from candidates and on behalf of candidates is encouraged. <u>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</u>Electronic messages <del>to contact electors should be minimized, and if used</del> must include a simple mechanism to allow recipients to opt out of receiving future messages.</p>	<p>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.</p>



<b>ETF 2 Proposed Language</b> <i>(Proposed changes to current policy or items from ETF 2 I-23 report shown in red)</i>	<b>Rationale</b>
<p><i>Proposed changes to current policy:</i></p> <p>Groups conducting interviews with <u>announced</u> candidates for a given office must offer an interview to all <del>individuals that have officially announced their candidacy at the time the group's interview schedule is finalized</del> <u>announced candidates</u> at the time the group's interview schedule is finalized.</p> <p>a. A group may meet with an <u>announced</u> candidate who is a member of their group <u>during the active campaign window</u> without interviewing other candidates for the same office.</p> <p>b. Interviewing groups may, but are not required to, interview <del>late announcing candidates persons who become announced candidates during the active campaign window</del>. 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.</p> <p>c. <del>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.</del> Any <u>appearance campaign-related presentation</u> 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.</p>	<p>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.</p>
<p><i>New language referred at I-23 with proposed changes.</i></p> <p>Candidates may not produce a personal <u>campaign-related</u> website <u>or other digital campaign-related content</u> or direct to personal or professional websites <u>that contain campaign materials</u> other than the AMA Candidates' Page.</p>	<p>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.</p>

<b>ETF 2 Proposed Language</b> <i>(Proposed changes to current policy or items from ETF 2 I-23 report shown in red)</i>	<b>Rationale</b>
<p><i>Proposed changes to current policy:</i></p> <p>Active campaigning for <del>AMA elective office an elected position</del> may not begin until the <u>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.</u></p>	<p>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.</p>
<p><i>New language referred at I-23 with proposed changes.</i></p> <p>Candidates <del>and their identified members of campaign teams</del> will be provided a copy of the current election rules and will be required to attest to abiding by them. <u>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.</u></p>	<p>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.</p>
<p><i>New item referred at I-23 (shown below) with proposed new language:</i></p> <p><del>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.</del></p> <p><i>[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.]</i></p>	<p>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.</p>

## REPORT OF THE SPEAKERS

Speakers' Report 03-A-24

Subject: Updated Parliamentary Authority

Presented by: Lisa Bohman Egbert, MD, Speaker, and John H. Armstrong, MD, Vice Speaker

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1 Recently, the American Institute of Parliamentarians Standard Code of Parliamentary Procedure,  
2 was updated and is now referenced as AIPSC (2<sup>nd</sup> ed.), with changes taking effect in January of  
3 2024. AMA Bylaw 11.1, Parliamentary Procedures, last amended in 2015, states that “In the  
4 absence of any provisions to the contrary in the Constitution and these Bylaws, all general  
5 meetings of the AMA and all meetings of the House of Delegates, of the Board of Trustees, of  
6 Sections and of councils and committees shall be governed by the parliamentary rules and usages  
7 contained in the then current edition of The American Institute of Parliamentarians Standard Code  
8 of Parliamentary Procedure.”

9  
10 When the AMA House of Delegates (HOD) adopted AIPSC as its parliamentary authority in 2015,  
11 there were only minor differences between it and AMA’s past parliamentary practices and  
12 traditions as embodied in the *HOD Reference Manual*. These were discussed in detail in Speakers  
13 Report 1-A-16, which was adopted by the HOD. Adoption allowed the HOD to retain some  
14 historical parliamentary practices and traditions, including requiring debate on both sides prior to  
15 closing debate on a subject, separate motions of refer for report and refer for decision (AIPSC uses  
16 a single motion of refer), the motion to table, and AMA’s historical practice of considering all  
17 matters acted upon at a meeting to be final, meaning that items from one meeting are not subject to  
18 a motion to recall from committees, a motion to reconsider or any other motion at a subsequent  
19 meeting. Adoption also created the motion to Object to Consideration requiring a 3/4 majority vote.  
20 Specific AMA bylaws focusing on withdrawal of resolutions, also remained in place: 2.11.3.1.5  
21 allows a sponsor to withdraw a resolution at any time prior to its acceptance as business by the  
22 HOD, and 2.13.1.7.4, which provides that if, in the judgment of the sponsor and of the reference  
23 committee, it appears that withdrawal is preferable to presentation for action, the reference  
24 committee may recommend withdrawal to the HOD in its report, with the Proceedings noting only  
25 that the resolution was withdrawn. Adoption of Speakers Report 1-A-16 also led to subsequently  
26 amended and adopted bylaws related to late and emergency resolutions.

27  
28 The Speakers, in concert with the Council on Constitution and Bylaws, have reviewed the AIPSC  
29 (2<sup>nd</sup> ed.) and compared the rules therein to usual practice in the House of Delegates and in the  
30 *House of Delegates Reference Manual: Procedures, Policies and Practices*. The *HOD Reference*  
31 *Manual* delineates the HOD’s Standing Rules, and is presented in a Rules Report that is adopted  
32 by the HOD at each meeting by majority vote, with the Rules Report stating that the *HOD*  
33 *Reference Manual* shall be the official method of procedure in handling and conducting the  
34 business of the AMA House of Delegates. [The AIPSC (2<sup>nd</sup> ed.) is available for purchase on  
35 Amazon in Kindle and print versions.]

1 AIPSC (2<sup>nd</sup> ed.) identified the following as among the substantive changes:  
2

- 3 • Replacing the concept of restricted debate with a requirement that debate be germane to the  
4 motion at hand. (No change required as this is current AMA practice. Note, this would also  
5 be inclusive of motions to refer, reconsider and postpone debate.);  
6
- 7 • Making Close Debate and Vote Immediately amendable as to the motions to which it  
8 applies. **(Rather than making the motion amendable, your Speakers have elected to  
9 continue our current AMA practice in which the maker of the motion may specify to  
10 which items they wish to apply the motion with the caveat that both sides must have  
11 been heard on each item);**  
12
- 13 • Removing the debatability of motions that limit debate. **(The motions Object to  
14 Consideration\* and Limit or Extend Debate will no longer be debatable);**  
15  
*\*The motion Object to Consideration requires a 3/4 vote and is unique to the AMA. This was adopted  
16 by the HOD at A-16. However, as it limits debate, it will no longer be debatable.*  
17  
18
- 19 • Removing the concept of a substitute amendment. (No change required as current AMA  
20 practice treats substitute amendments as motions to adopt in lieu of);  
21
- 22 • Establishing that after debate has been closed, Factual Inquiries are not permitted, although  
23 a Parliamentary Inquiry may be. **(This rule will be implemented);**  
24
- 25 • Clarifying the methodology and motions used to create a continued meeting. (No change  
26 required as AMA items of business are not held over for future meeting);  
27
- 28 • Some Main Motions have been retitled as Specific-Purpose Main Motions. (Retitled  
29 appropriately on the HOD Reference Manual's Parliamentary Quick Tips Chart, which is  
30 appended to this report);  
31
- 32 • Special Orders were renamed Scheduled Orders. (Not applicable);  
33
- 34 • Standing Rules are now designated as "Standing Rules of Order" or "Temporary Rules.  
35 **(The House of Delegates Reference Manual constitutes our Standing Rules of Order.  
36 These are highlighted in the Rules Report along with any Temporary Rules for that  
37 meeting.);**  
38
- 39 • Clarifying rules related to the Credentials Committees, whereby the initial Credentials  
40 Committee lists the names of members entitled to vote. (Not applicable as the current  
41 AMA practice is to identify credentialed delegates in "The Official Call" with the  
42 Committee on Rules and Credentials reporting each day only the number of credentialed  
43 delegates in attendance and whether a quorum has been met. The HOD Proceedings reflect  
44 the final listing of members of the HOD.)  
45

46 The nuances of these changes are addressed in the *HOD Reference Manual* and incorporated into  
47 the "Parliamentary Quick Tips" chart that appears as an appendix in the HOD Reference Manual  
48 and which is attached to this report also. The Rules Report, to be presented at A-24, will once again  
49 ask the HOD to adopt the *HOD Reference Manual* as the official method of procedure in handling  
50 and conducting the business of the AMA House of Delegates.

1 There also are several other changes that require additional action: AIPSC (2<sup>nd</sup> ed.) establishes  
2 electronic notice (of a meeting) as the default notification and there are several bylaw provisions  
3 (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  
4 Council has submitted amended bylaw language via CCB Report 4-A-24, AMA Bylaw  
5 Amendments Pursuant to AIPSC (2<sup>nd</sup> 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.

**Procedures**

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		May Interrupt Speaker?	Requires a Second?	Is motion debatable?	May be Amended?	Vote Needed?
<b>Privileged</b>	Adjourn the meeting	No	Yes	No	Yes	Majority
	Recess the meeting	No	Yes	No	Yes	Majority
	Question of privilege <sup>1</sup>	Yes	No	No	No	None
<b>Subsidiary</b>	Object to consideration <sup>2</sup>	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 <sup>3</sup>	No	Yes	Yes	Yes	Majority
	Referred for report	No	Yes	Yes	Yes	Majority
	Amend	No	Yes	Yes	Yes	Majority
<b>Main</b>	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
<b>Incidental</b>	<b>Motions</b>					
	Appeal a decision by the Speaker	Yes	Yes	Yes	No	Majority
	Suspend the Rules	No	Yes	No	No	Two-thirds
	<b>Requests</b>					
	Point of order <sup>4</sup>	Yes	No	No	No	None
	Inquiries <sup>5</sup>	Yes	No	No	No	None
	Division of question	No	No	No	No	None
	Division of House	Yes	No	No	No	None

**Definitions:**

- <sup>1</sup> 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.
- <sup>2</sup> 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 (2<sup>nd</sup> ed.) as it limits debate, it will no longer be debatable.
- <sup>3</sup> 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.
- <sup>4</sup> 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.
- <sup>5</sup> 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)

\* 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.