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

The Consolidated Financial Statements for the years ended December 31, 2023 and 2022 and the Independent Auditor’s report have been included in the 2023 Annual Report. This is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.
This informational financial report details all grants or donations received by the American Medical Association during 2023.
## American Medical Association
### Grants & Donations Received by the AMA
#### For the Year Ended December 31, 2023

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

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

PURPOSE

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

BACKGROUND

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

YEAR 2023 RESULTS

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

CONCLUSION

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

CORPORATE REVIEW PROCESS OVERVIEW

The Corporate Review Team (CRT) includes senior managers from the following areas: Strategy, Finance, Health Solutions (HS), Advocacy, Office of the General Counsel, Medical Education, Publishing, Enterprise Communications (EC), Marketing and Member Experience (MMX), Center for Health Equity (CHE), and Health, Science and Ethics.

The CRT evaluates each project submitted to determine fit or conflict with AMA Corporate Guidelines, covering:

- Type, purpose, and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA name and logo;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

The CRT reviews and makes recommendations regarding the following types of activities that utilize AMA name and logo:

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

For the above specified activities, if the CRT recommends approval, the project proceeds. In addition to CRT review, the Executive Committee of the Board must review and approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.
• Single-sponsor activities that do not meet ACCME Standards and Essentials.
• Activities involving risk of substantial financial penalties for cancellation.
• Upon request of a dissenting member of the CRT.
• Any other activity upon request of the CRT.

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

## SUMMARY OF CORPORATE REVIEW

### RECOMMENDATIONS FOR 2023

## CONFERENCES/EVENTS

<table>
<thead>
<tr>
<th>Project Number</th>
<th>Project Description</th>
<th>Corporations</th>
<th>Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>21890</td>
<td>March of Dimes Gourmet Gala - Repeat sponsorship with AMA name and logo.</td>
<td>March of Dimes, Samsung, Proctor and Gamble, Abbott Pharmaceuticals, Barbour Griffiths and Rogers Group, PhRMA</td>
<td>01/24/2023</td>
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<tr>
<td>21987</td>
<td>HIMSS Global Health Conference &amp; Exhibition - Repeat sponsorship with AMA and CPT names and logos.</td>
<td>Health Information and Management Systems Society</td>
<td>02/02/2023</td>
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<td>22011</td>
<td>Public Relations Student Society of America Midwest District Conference – Sponsorship with AMA name and logo.</td>
<td>Public Relations Student Society of America, Public Relations Society of America</td>
<td>02/06/2023</td>
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<td>22026</td>
<td>NAMSS 47th Annual Educational Virtual Conference and Exhibition - Repeat sponsorship with AMA name and logo.</td>
<td>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</td>
<td>02/07/2023</td>
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<tr>
<td>Event Code</td>
<td>Event Name</td>
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<td>Sponsorship Details</td>
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<td>22039</td>
<td>AHCJ Conference</td>
<td>Repeat sponsorship with AMA and JAMA Network names and logos.</td>
<td>Association of Healthcare Journalists</td>
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<td>22132</td>
<td>IAIABC 109th Convention</td>
<td>Repeat sponsorship with AMA name and logo.</td>
<td>International Association of Industrial Accident Boards and Commissions</td>
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<td>National Council on Compensation Insurance</td>
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<td>Sedgwick</td>
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<td>The Black Car Fund</td>
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<td>Aerie EDI Group</td>
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<td>Safety National Healthesystems</td>
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<td>Official Disability Guidelines by Milliman Clinical Guidelines</td>
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<td>HealthTech, Inc</td>
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<td>Rising Medical Solutions</td>
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<td>22123</td>
<td>AAPC HEALTHCON Events</td>
<td>Repeat sponsorship with AMA name and logo.</td>
<td>American Academy of Professional Coders</td>
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<td>22064</td>
<td>National Rx &amp; Illicit Drug Summit</td>
<td>Repeat sponsorship with AMA name and logo.</td>
<td>Operation Unite Police Treatment and Community Collaborative</td>
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<td>Georgia Council for Recovery</td>
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<td>Brevard Prevention Coalition</td>
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<td>Advantage Behavioral Health</td>
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<td>Emergency Medical Services World</td>
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<td>22120</td>
<td>AMA Research Challenges</td>
<td>AMA branded competition repeat event with Laurel Road sponsored prize.</td>
<td>Laurel Road Bank</td>
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<td>Key Bank</td>
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<td>22283</td>
<td><strong>National Black Law Students Association Convention</strong> – Sponsorship with AMA name and logo.</td>
<td>National Black Law Students Association Haynes Boone Holland &amp; Knight Alston &amp; Bird</td>
<td>02/24/2023</td>
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<tr>
<td>22121</td>
<td><strong>Becker’s Collaborations - Webinar, CEO &amp; CFO Roundtables and Luncheon, and Annual Hospital Review.</strong></td>
<td>Becker’s Hospital Review ASC Communications</td>
<td>02/24/2023</td>
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<td>22194</td>
<td><strong>ViVE 2023 Sponsorship</strong> – Repeat sponsorship with AMA name and logo.</td>
<td>HLTH Inc College of Healthcare Information Management Executives (CHIME)</td>
<td>03/02/2023</td>
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<td>22323</td>
<td><strong>Rock Health Summit</strong> – Repeat sponsorship with AMA name and logo.</td>
<td>Rock Health Foundation California Health Care Foundation Google Tulsa Innovation Labs 1501 Health BioReference Laboratories</td>
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<td>22209</td>
<td><strong>AMA International Medical Graduates Section (IMGS) Annual Meeting Desserts Reception</strong> – Repeat sponsorship with AMA name and logo.</td>
<td>Association of Physicians of Pakistani Descent of North America Association of Haitian Physicians Abroad Korean American Medical Association National Arab Medical Association</td>
<td>03/09/2023</td>
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<td>22364</td>
<td><strong>Chicago Cares - Find your Cause Event</strong> – Sponsorship with AMA name and logo.</td>
<td>Chicago Cares</td>
<td>03/15/2023</td>
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<td>22462</td>
<td><strong>National Hispanic Medical Association 26th Annual Conference</strong> – Repeat sponsorship with AMA name and logo.</td>
<td>National Hispanic Medical Association</td>
<td>03/17/2023</td>
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<td>22454</td>
<td><strong>Asian American Journalists Association’s Annual Convention</strong> – Repeat sponsorship with AMA name and logo.</td>
<td>Asian American Journalists Association</td>
<td>03/20/2023</td>
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</table>
| 22540 | **Credentialing State Shows** – Repeat sponsorship with AMA name and logo.        | Texas Society for Medical Services Specialists  
Illinois Association of Medical Staff Services  
North Carolina Association of Medical Staff Services  
California Society for Medical Services Specialists  
MD Staff  
PreCheck  
Canadian International Medical Relief Organization  
Critical Incident Management Response Organization (CIMRO)  
Hardenbergh Group  
MD Review  
Qgenda  
YS Credentialing  
American Board of Medical Specialties Solutions | 03/23/2023 |
<p>| 22603 | <strong>Reuters Digital Health, Reuters Momentum Events</strong> – Conference sponsorships with AMA name and logo. | Reuters Events                  | 04/04/2023 |
| 22697 | <strong>AMA Medical Education AAMC Webinar</strong> – Co-branded sponsorship with AMA name and logo. | Association of American Medical Colleges | 04/14/2023 |</p>
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<tr>
<th>Event ID</th>
<th>Event Description</th>
<th>Sponsorship Details</th>
<th>Date</th>
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<td>22707</td>
<td>National Independent Laboratory Association Annual Meeting – Repeat sponsorship with AMA name and logo.</td>
<td>Agena Bioscience, Seegene Technologies, Streamline Scientific, TELCOR, Quarles &amp; Brady LLP</td>
<td>04/17/2023</td>
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<td>22899</td>
<td>Rush University Medical Center - West Side Walk for Wellness – Repeat sponsorship with AMA name and logo.</td>
<td>Rush University Medical Center West Side Walk for Wellness</td>
<td>05/02/2023</td>
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<td>22842</td>
<td>National Multiple Sclerosis Society 45th Annual Ambassadors Ball – Sponsorship with AMA name and logo.</td>
<td>National Multiple Sclerosis (MS) Society</td>
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<td>23081</td>
<td>Essence Festival – Sponsorship with In Full Health name and logo.</td>
<td>New Voices Foundation Essence Festival</td>
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<tr>
<td>23152</td>
<td>“Walking Backward into the Future of Chicago’s West Side” Event – Sponsorship with AMA name and logo.</td>
<td>Medical Justice in Advocacy Fellowship Morehouse School of Medicine</td>
<td>05/24/2023</td>
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<td>23115</td>
<td>The Systems Summit on Clinical Wellbeing at Princeton University - Sponsorship with AMA name and logo.</td>
<td>Princeton Center for Health and Wellbeing The Samuei Foundation Kahneman-Treisman Center for Behavioral Science &amp; Public Policy at Princeton Healing Works Foundation American College of Graduate Medical Education</td>
<td>06/08/2023</td>
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<td>23441</td>
<td>American Society of Bioethics and Humanities Conference – Sponsorship with AMA Journal of Ethics name and logo.</td>
<td>American Society of Bioethics and Humanities</td>
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| 23394  | **National Adult and Influenza Immunization Summit** – Sponsorship with AMA name and logo. | Centers for Disease Control and Prevention  
Office of Infectious Disease and HIV/AIDS Policy  
U.S. Department of Health and Human Services  
Immunize.org | 06/29/2023 |
| 23453  | **NAACOS Fall Conference** – Sponsorship with AMA MAP name and logo. | National Association of Accountable Care Organizations | 06/30/2023 |
| 23420  | **SNOMED CT Expo** – Repeat sponsorship with AMA CPT and AMA names and logos. | Systematized Nomenclature of Medicine (SNOMED) International | 07/06/2023 |
| 23656  | **Chief Medical Officer Exchange** – Sponsorship with AMA name and logo. | HCPro  
HealthLeaders  
Nuance Healthcare Solutions  
3M M*Modal  
Midmark | 07/21/2023 |
| 23083  | **ASMAC Fall Conference** - Sponsorship with AMA name and logo. | American Society of Medical Association Counsel | 07/25/2023 |
| 23742  | **American Conference on Physician Health** – Repeat sponsorship with AMA name and logo. | Stanford Medicine  
Mayo Clinic  
The Physician’s Foundation  
Nuance Communications | 07/27/2023 |
| 23838  | **WOEMA Conference** - Sponsorship with AMA name and logo. | Western Occupational and Environmental Medical Association  
The Permanente Group  
Concentra Occupational Health  
e3 Occupational Health Solutions  
Novo Nordisk | 08/02/2023 |
<table>
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<th>Date</th>
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<tr>
<td>23865</td>
<td>GCC eHealth Workforce Development Conference – Repeat sponsorship with AMA name and logo.</td>
<td>Gulf Cooperation Council Emirates Health Services InterSystems Malaffi CyncHealth Dell Technologies</td>
<td>08/07/2023</td>
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<td>23891</td>
<td>CFHA Integrated Care Conference – Repeat sponsorship with AMA name and logo.</td>
<td>Collaborative Family Healthcare Association</td>
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<td>23932</td>
<td>Genetic Health Information Network Summit - Repeat sponsorship with AMA name and logo.</td>
<td>Concert Genetics Illumina Sarah Lawrence Genomics Institute</td>
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<tr>
<td>23939</td>
<td>HMPRG Awards Gala – Sponsorship with AMA name and logo.</td>
<td>Health &amp; 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!</td>
<td>08/15/2023</td>
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<tr>
<td>24037</td>
<td>HLTH Conference - Repeat sponsorship with AMA name and logo</td>
<td>HLTH Inc HLTH Foundation</td>
<td>08/17/2023</td>
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<tr>
<td>Date</td>
<td>Event Description</td>
<td>Sponsors/Partners</td>
<td>Date</td>
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<tr>
<td>08/22/2023</td>
<td>Alliance for Health Policy - Annual Dinner – Repeat sponsorship with AMA name and logo.</td>
<td>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 &amp; Stowe, ADVI Health</td>
<td>08/22/2023</td>
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24036  APHC Conference
Sponsorship – Sponsorship with AMA name and logo.

Academy for Professionalism in Health Care
Case Western Reserve University
Cleveland Clinic: Lerner College of Medicine
American Board of Medical Specialties
Loma Linda University Health
Johns Hopkins Berman Institute of Bioethics
Loyola Bioethics
American Association of Colleges of Osteopathic Medicine
The Arnold P. Gold Foundation
American Board of Internal Medicine Foundation
Saint Louis University: Albert Gnaegi Center for Health Care Ethics

08/31/2023

23750  NOAH Conference - Sponsorship with AMA name and logo.

National Organization for Arts in Health
Cleveland Clinic
MetroHealth System
Laurie M. Tisch Illumination Fund
Museum Exchange
Houston Methodist Hospital
University of Rochester
Stanford Medicine
Aesthetics Inc.
J.T. & Margaret Talkington College of Visual & Performing Arts at Texas Tech University
Northwest Creative & Expressive Arts Institute

08/31/2023

24376  National Addiction Treatment Week - Repeat sponsorship with AMA name and logo.

American Society for Addiction Medicine
Association of American Medical Colleges
American College of Academic Addiction Medicine
American Osteopathic Academy of Addiction Medicine
Michigan Cares
National Institute on Drug Abuse
National Institute on Alcohol Abuse and Alcoholism
University of California San Francisco Smoking Cessation Leadership Center

09/21/2023
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<th>Event Title</th>
<th>Sponsorship Details</th>
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<td>24703</td>
<td><strong>Black Men in White Coats Youth Summit - Repeat</strong> sponsorship with AMA name and logo.</td>
<td>Black Men in White Coats Veradigm Creating Pathways and Access for Student Success (CPASS) Foundation</td>
<td>10/16/2023</td>
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<td>24773</td>
<td><strong>Hispanic Health Professional Student Scholarship Gala – Sponsorship with AMA name and logo.</strong></td>
<td>National Hispanic Health Foundation National Hispanic Medical Association</td>
<td>11/01/2023</td>
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<td>25041</td>
<td><strong>HLTH Foundation Webinar - Sponsorship with AMA name and logo.</strong></td>
<td>HLTH Inc HLTH Foundation</td>
<td>11/20/2023</td>
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<tr>
<td>24941</td>
<td><strong>Consumer Electronics Show Digital Health Conference - Sponsorship with AMA name and logo.</strong></td>
<td>Consumer Technology Association American Psychological Association Connectivity Standards Alliance</td>
<td>11/22/2023</td>
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<td>25305</td>
<td><strong>MD-Staff Educational Conference - Sponsorship with AMA name and logo.</strong></td>
<td>Applied Statistics &amp; Management PreCheck The Hardenbergh Group Sterling Infosystems</td>
<td>12/07/2023</td>
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## EDUCATIONAL CONTENT OR GRANT

<table>
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<tr>
<th>Project Number</th>
<th>Project Description</th>
<th>Corporations</th>
<th>Approval Date</th>
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<tr>
<td>21752</td>
<td>Words Matter-Making Sense of Health Equity Language Session – Recording for Medscape’s CME &amp; Education platform with AMA name and logo.</td>
<td>Medscape, Association of American Medical Colleges</td>
<td>01/10/2023</td>
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<td>22334</td>
<td>Parkinson’s Foundation Education Series - AMA EdHub hosted content with AMA name and logo.</td>
<td>Parkinson’s Foundation, CVS Health Foundation</td>
<td>03/22/2023</td>
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<tr>
<td>22712</td>
<td>AMA STEPS Forward® Plan-Do-Study-Act (PDSA) Toolkit – Update to toolkit hosted on AMA EdHub with AMA name and logo.</td>
<td>Center for Sustainable Health Care Quality and Equity, National Minority Quality Form, American College of Physicians</td>
<td>04/18/2023</td>
</tr>
<tr>
<td>23035</td>
<td>Advancing AMA’s Telehealth Policy Report – Co-branded research report on telehealth priorities and trends, with AMA name and logo.</td>
<td>Manatt Health</td>
<td>05/30/2023</td>
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<tr>
<td>23094</td>
<td>Future of Health Immersion Program – Collaborators for AMA website program on telehealth.</td>
<td>The Physician’s Foundation, American Physical Therapy Association, Health Choice Network, Academy of Medicine of Cleveland and Northern Ohio</td>
<td>06/06/2023</td>
</tr>
<tr>
<td>23810</td>
<td>Disability Inclusion in Undergraduate and Graduate Medical Education Modules - AMA EdHub hosted content with AMA name and logo.</td>
<td>Association of Higher Education and Disability Docs with Disabilities Initiative, Association of American Medical Colleges</td>
<td>08/01/2023</td>
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<td>24016</td>
<td>National Coalition for Sexual Health - AMA EdHub hosted content with AMA name and logo.</td>
<td>National Coalition for Sexual Health, Altarum Institute</td>
<td>09/07/2023</td>
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<tr>
<td>Project Number</td>
<td>Project Description</td>
<td>Corporations</td>
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<td>24576</td>
<td>American Health Information Management Association Workshop – Training on clinical documentation coding with AMA name and logo.</td>
<td>American Health Information Management Association</td>
<td>10/10/2023</td>
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<tr>
<td>24905</td>
<td>Credentialing School Sponsorship - Repeat sponsorship with AMA name and logo.</td>
<td>Edge-U-Cate</td>
<td>11/08/2023</td>
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<td>Certi-FACTS</td>
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<td>Symplr</td>
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<td>Federation of State Medical Boards</td>
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<td>24629</td>
<td>Natural Resources Defense Council - AMA EdHub hosted environmental health content with AMA name and logo.</td>
<td>Natural Resources Defense Council</td>
<td>11/10/2023</td>
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COLLABORATIONS/ AFFILIATIONS

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

HLTH Foundation – Sponsorship of equity research coalition and conference with AMA name and logo.

HLTH Foundation
Ipsos Group S.A.

MassChallenge HealthTech – Sponsorship of healthcare startup mentorship program with AMA name and logo.

MassChallenge
Lyda Hill Philanthropies
Accenture
Boston Children’s Hospital
Brigham Health and Women’s Hospital

02/27/2023
04/12/2023
<table>
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<tr>
<th>22833</th>
<th><strong>“The PermanenteDocs Chat” Podcast Program</strong> - Collaboration for bi-weekly podcast program with AMA name and logo.</th>
</tr>
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</table>
| 04/20/2023 | The Permanente Federation
Kaiser Permanente |

<table>
<thead>
<tr>
<th>22820</th>
<th><strong>The Collaborative for Healing and Renewal in Medicine (CHARM)</strong> - Charter committed to reducing healthcare worker burnout with AMA name and logo.</th>
</tr>
</thead>
</table>
| 05/01/2023 | Alaska Native Medical Center
Allegheny Health Network
American Medical Women's Association
Brigham & Women's Hospital
CareMax
ChenMed
Children's Hospital of Los Angeles
Dayton Children's Hospital
Drexel University
First Choice Community Healthcare
HonorHealth
Keck School of Medicine, University of Southern California
Luminis Health
Mercy Medical Center
New York City Health
Northwest Permanente PD
Olive View-UCLA Medical Center
Oregon Health & Science University
Palo Alto Foundation Medical Group
Piedmont Medical Center
Pomona Valley Hospital Medical Center
Queen's Health System
Rogers Behavioral Health
Roper St. Francis Healthcare
St. Jude Heritage Medical Group
St. Luke's Health System
Stamford Hospital
University of Michigan Health-West
University of Texas Medical Branch
US Acute Care Solutions
Washington Permanente Medical Group
Yale New Haven Hospital |
<table>
<thead>
<tr>
<th>Code</th>
<th>Project/Coalition/Update</th>
<th>Collaborators</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>23018</td>
<td><strong>Rise to Health Coalition Collaborator Update</strong> – Co-branded coalition to embed equity in healthcare including toolkits, webinars and guides for healthcare professionals.</td>
<td>National Committee for Quality Assurance, American Association of Retired Persons, American Nursing Association, Bristol Myers Squibb</td>
<td>05/17/2023</td>
</tr>
<tr>
<td>23079</td>
<td><strong>National Health Equity Grand Rounds Collaborator Update</strong> - Webinar series on health equity with AMA name and logo.</td>
<td>Social Mission Alliance</td>
<td>05/23/2023</td>
</tr>
<tr>
<td>23142</td>
<td><strong>National Association of Accountable Care Organizations Alliance Partner</strong> – Membership to advance value-based care with AMA name and logo.</td>
<td>Primary Care Collaborative, Center for Sustainable Healthcare, Epic Systems, Surescripts, Blue Cross Blue Shield of South Carolina</td>
<td>05/25/2023</td>
</tr>
<tr>
<td>23292</td>
<td><strong>Improving Health Outcomes Research Collaboration</strong> - UCSF feasibility study for wrist worn blood pressure monitoring devices.</td>
<td>University of California San Francisco, LiveMetric</td>
<td>06/16/2023</td>
</tr>
<tr>
<td>23440</td>
<td><strong>Facility Closure Impact on Access to Maternity Care</strong> – Co-branded research report regarding impact of facility closures on access to maternity care in Chicago.</td>
<td>March of Dimes, Sinai Urban Health Institute</td>
<td>07/05/2023</td>
</tr>
<tr>
<td>23437</td>
<td><strong>Connecting to Coverage Coalition</strong> – Outreach program collaboration to promote Medicaid enrollment with AMA name and logo.</td>
<td>America’s Health Insurance Plans, Thorn Run Partners</td>
<td>07/10/2023</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Collaborators</td>
<td>Date</td>
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<tr>
<td>23542</td>
<td><strong>VeriCre</strong> – Pilot program collaboration for new AMA credentialing product with AMA name and logo.</td>
<td>Applied Statistics and Management MD-Staff SC Health Cleveland Clinic Boston Children’s Hospital Mass General Brigham Council for Affordable Quality Healthcare HealthStream</td>
<td>07/14/2023</td>
</tr>
<tr>
<td>23512</td>
<td><strong>Health Equity in Organized Medicine Survey</strong> - Collaboration on report summarizing survey findings with AMA name and logo.</td>
<td>MyWhy Agency</td>
<td>07/20/2023</td>
</tr>
<tr>
<td>23714</td>
<td><strong>Reuters Total Health</strong> – Collaboration for report regarding industry challenges with AMA name and logo.</td>
<td>Reuters Kaiser Permanente GE Healthcare Dartmouth Health Sutter Health Ardent Health Center for Medicare Northwell Health</td>
<td>07/26/2023</td>
</tr>
<tr>
<td>24025</td>
<td><strong>Advancing Rural Behavioral Health Integration with Telehealth Research Program</strong> – Collaborative study with AMA name and logo.</td>
<td>University of Hawaii John A. Burns School of Medicine The Physicians Foundation</td>
<td>08/18/2023</td>
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<tr>
<td>Code</td>
<td>Description</td>
<td>Partner(s)</td>
<td>Date</td>
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<tr>
<td>24404</td>
<td>Joy in Medicine Health System Recognition Program - Repeat AMA recognition program for outstanding healthcare organizations.</td>
<td>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</td>
<td>09/25/2023</td>
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<tr>
<td>24250</td>
<td>New MAP BP program distribution channel partner – Collaboration to distribute MAP materials with AMA name and logo.</td>
<td>Altarum Institute</td>
<td>10/02/2023</td>
</tr>
<tr>
<td>24306</td>
<td>Joint announcement for Social Needs Assessment Coder – Press release to announce new program with AMA name and logo.</td>
<td>The Gravity Project</td>
<td>10/03/2023</td>
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<tr>
<td>24518</td>
<td>Mathematica Physician Practice Information Survey – Collaborative study on physician costs with AMA name and logo.</td>
<td>Mathematica</td>
<td>10/05/2023</td>
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<tr>
<td>24453</td>
<td>Physician Data Collaborative – Website launch with AMA name and logo.</td>
<td>Association of American Medical Colleges Accreditation Council of Graduate Medical Education</td>
<td>10/09/2023</td>
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<tr>
<td>ID</td>
<td>Description</td>
<td>Organization</td>
<td>Date</td>
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<tr>
<td>24616</td>
<td><strong>MATTER Chicago</strong> – Repeat sponsorship of nonprofit healthcare startup incubator with AMA name and logo.</td>
<td>Matter Chicago</td>
<td>10/10/2023</td>
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<tr>
<td>24558</td>
<td><strong>Prevention Strategy Collaboration with Health Care Organizations</strong> – Update to program with AMA name and logo.</td>
<td>River Valley Family Healthcare</td>
<td>10/13/2023</td>
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<tr>
<td>24593</td>
<td><strong>Embedding Equity in Crisis Preparedness &amp; Response in Health Systems Guide</strong> – Update to materials with AMA name and logo.</td>
<td>Planned Parenthood Federation of America&lt;br&gt;Reproductive Health Impact&lt;br&gt;American Public Health Association&lt;br&gt;New York City Pandemic Response Institute&lt;br&gt;For the Culture Consulting, LLC</td>
<td>10/23/2023</td>
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<tr>
<td>24617</td>
<td><strong>VALID AI</strong> – Membership in working group on AI in healthcare with AMA name and logo.</td>
<td>University of California Davis Health&lt;br&gt;Moffit Cancer Center&lt;br&gt;Cleveland Clinic&lt;br&gt;Elevance&lt;br&gt;MedStar&lt;br&gt;Microsoft&lt;br&gt;Google</td>
<td>10/23/2023</td>
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<tr>
<td>24714</td>
<td><strong>Physician Innovation Network (PIN)</strong> – AMA PIN collaboration agreements with limited AMA name and logo use.</td>
<td>American Academy of Pain Medicine&lt;br&gt;Microsoft Startup Accelerator</td>
<td>11/03/2023</td>
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<tr>
<td>24872</td>
<td><strong>Teaching Case on AMA’s Center for Health Equity</strong> – Collaboration to develop a case study with AMA name.</td>
<td>Harvard TH Chan School of Public Health</td>
<td>11/06/2023</td>
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<tr>
<td>24989</td>
<td><strong>Common Health Coalition: Together for Public Health</strong> – Collaboration on pandemic preparedness with AMA name and logo.</td>
<td>America’s Health Insurance Plans&lt;br&gt;Alliance of Community Health Plans&lt;br&gt;American Hospital Association&lt;br&gt;Kaiser Permanente</td>
<td>11/15/2023</td>
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</table>
### Henry Schein Cares Foundation “Prevention is Power” Initiative – Collaboration on public health awareness campaign with AMA and Release the Pressure (RTP) names and logos.

Henry Schein Cares Foundation  
American Dental Association  
National Association of Community Health Centers  
CDC Foundation  
National Medical Association  
12/06/2023

### MEMBER PROGRAMS

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

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

INTRODUCTION

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

IMPROVING THE AFFORDABLE CARE ACT

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

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

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

Cover Uninsured Eligible for ACA’s Premium Tax Credits
• The AMA advocates for increasing the generosity of premium tax credits to improve premium affordability and incentivize tax credit eligible individuals to get covered. Currently, eligible individuals and families with incomes between 100 and 400 percent federal poverty level (FPL) (133 and 400 percent in Medicaid expansion states) are being provided with refundable and advanceable premium tax credits to purchase coverage on health insurance exchanges.

• The AMA has been advocating for enhanced premium tax credits for young adults. In order to improve insurance take-up rates among young adults and help balance the individual health insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium tax credits could be provided with “enhanced” premium tax credits—such as an additional $50 per month—while maintaining the current premium tax credit structure that is inversely related to income, as well as the current 3:1 age rating ratio.

• The AMA is also advocating for an expansion of the eligibility for and increasing the size of cost-sharing reductions. Currently, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which leads to lower deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts. Extending eligibility for cost-sharing reductions beyond 250 percent FPL, and increasing the size of cost-sharing reductions, would lessen the cost-sharing burdens many individuals face, which impact their ability to access and afford the care they need.

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

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

• The AMA has been advocating for increasing and improving Medicaid/CHIP outreach and enrollment, including auto enrollment.

• The AMA has been opposing efforts to establish Medicaid work requirements. The AMA believes that Medicaid work requirements would negatively affect access to care and lead to significant negative consequences for individuals’ health and well-being.

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

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

• The AMA advocates for eliminating the subsidy “cliff,” thereby expanding eligibility for premium tax credits beyond 400 percent FPL.

• The AMA has been advocating for the establishment of a permanent federal reinsurance program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher premiums across the board in anticipation of higher-risk people enrolling in coverage. Section 1332 waivers have also been approved to provide funding for state reinsurance programs.
The AMA also is advocating for lowering the threshold that determines whether an employee’s premium contribution is “affordable,” allowing more employees to become eligible for premium tax credits to purchase marketplace coverage.

The AMA strongly advocated for the Internal Revenue Service regulation that was proposed on April 7, 2022 to fix the so-called “family glitch” under the ACA, whereby families of workers remain ineligible for subsidized ACA marketplace coverage even though they face unaffordable premiums for health insurance coverage offered through employers. The Biden Administration finalized the proposed rule on October 13, 2022. The regulation resolved the family glitch by extending eligibility for ACA financial assistance to only the family members of workers who are not offered affordable job-based family coverage.

EXPAND MEDICAID TO COVER MORE PEOPLE

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

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

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

AMERICAN RESCUE PLAN OF 2021

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

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

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

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

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

LEGISLATIVE EXTENSION OF ARPA PROVISIONS

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

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

ACA ENROLLMENT

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

CONTINUOUS MEDICAID ENROLLMENT

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

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

SGR REPEAL

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

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

INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

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

CONCLUSION

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

Subject: AMA Performance, Activities, and Status in 2023

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

INTRODUCTION

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

Representing physicians with a unified voice

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

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

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

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

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

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

Removing obstacles that interfere with patient care

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

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

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

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

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

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

Driving the future of medicine

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

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

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

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

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

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

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

Leading the charge to confront public health crises

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

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

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

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

**AMA Task Forces**

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

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

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

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

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

**Membership**

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

**EVP Compensation**

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

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

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

TOBACCO USE AT A GLANCE

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

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

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

The CDC and FDA analyzed data from the 2023 National Youth Tobacco Survey (NYTS) to assess tobacco product use patterns among U.S. middle school (grades 6–8) and high school (grades 9–12) students. This analysis was published in the November 3, 2023, MMWR. The NYTS is a cross-sectional, school-based, self-administered web-based survey of U.S. middle and high school students. A stratified, three-stage cluster sampling procedure was used to generate a nationally representative sample of U.S. students attending private or public middle (grades 6–8) and high...
Current use of any use of any tobacco product by high school students declined by an estimated 540,000, from 2.51 million in 2022 to 1.97 million in 2023. Declines were also reported for current e-cigarette use among high school students during that same period from 14.1 percent to 10.0 percent. While these declines demonstrate the effectiveness of tobacco control legislation and regulations, there is still cause for concern. E-cigarette products were the most used tobacco product of middle and high school students with 7.7 percent reporting current e-cigarette use followed by cigarettes at 1.6 percent. Among students who had ever used an e-cigarette, 46.7 percent reported current use and 89.4 percent of them used flavored products and 25.2 percent used an e-cigarette daily. Given the number of middle and high school students that use tobacco products, sustained efforts to prevent initiation of tobacco product use among young persons and strategies to help young tobacco users quit are critical to reducing U.S. youth tobacco product use.

Sales Use of E-Cigarettes Dominated by Flavored Products

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

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

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

EFFORTS TO ADDRESS TOBACCO CONTROL

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

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

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

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

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

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

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

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

Helping Tobacco Users Quit Act would expand and ensure cessation coverage

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

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

American Lung Association Releases its 2024 State of Tobacco Report

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

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

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

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

DISCUSSION

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

Embed Equity

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

- At the 2023 Annual and Interim House of Delegates Meetings, there were various equity-focused reports, resolutions, and educational sessions. The adopted Council on Ethical & Judicial Affairs (CEJA) Report on “Responsibilities to Promote Equitable Care” will be added to the AMA Code of Medical Ethics. Other notable reports included: **Ensuring Equity in Interview Processes for**
Entry to Undergraduate and Graduate Medical Education, Decreasing Bias in Assessments of Medical Student Clinical Clerkship, Support Removal of BMI as a Standard Measure in Medicine, Leave Policies for Medical Students, Residents, Fellows, and Physicians, Financial Burdens and Exam Fees for International Medical Graduates, Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict, Federally Qualified Heath Centers and Rural Health Care, and Medicaid Unwinding Update. The Council on Science and Public Health (CSAPH) and National Academy of Medicine (NAM) co-hosted an educational session at the Interim Meeting on climate crisis and health care decarbonization. Health Equity Open Fora were held at the Annual Meeting, highlighting the Rise to Health Coalition, LGBTQ leadership, and truth and reconciliation, and the Interim Meeting, focused on the Health Equity in Organized Medicine survey report and the next Equity Strategic Plan. Each forum had over 300 individuals in attendance.

- AMA strives toward the enterprise’s goal to raise its visibility in health equity and demonstrate its commitment to institutional and community partners. Website traffic related to health equity search was roughly 730,000 users. AMA published 127 news articles with health equity focus, representing 15 percent of its total production from the news team. Membership from users consuming health equity content increased 25 percent and referrals to health equity modules on Ed Hub from the AMA website increased 24 percent compared to the previous year. AMA update podcast downloads featuring health equity discussions increased 50 percent compared to the previous year, including more than 1,200 downloads. Approximately 15,000 learners completed AMA health equity courses for graduate and undergraduate medical education competency education programs (GCEP and UCEP). Major 2023 health equity announcements included the Rise to Health Coalition and the launch of the AMA’s Truth, Reconciliation, Healing and Transformation (TRHT) taskforce initiative.

  - The Council of Science and Public Health (CSAPH) presented a report on equity in precision medicine, with a four-episode podcast series in development for release in 2024.
  - To support reimagining the future of health equity and racial justice in medical education and improving the diversity of the health workforce, as directed by the Council on Medical Education's Report from June 2021, our AMA externally commissioned a diverse group of subject matter experts as editors who announced a call for authors, receiving over 150 submissions. Over 60 abstracts were published by the AMA in the compendium MedEd’s horizon: Just, merciful, diverse and equitable. The final forward-looking study with recommendations for action will be a book with approximately 18 chapters entitled Reimagining Medical Education, to be published by Elsevier in 2024, and intended for medical school and health system leaders, medical educators in undergraduate and graduate medical education (UME and GME), policy makers, change agents, and advocates.

  - AMA Journal of Ethics published four health equity-centered issues in 2023: Segregation in Health Care, Patient-Centered Transgender Surgical Care, How We Over Rely on BMI and Palliative Psychiatry, with the first issue including an article led by AMA staff: Training to Build Antiracist, Equitable Health Care Systems.

  - To help embed equity within public health, the AMA published, in collaboration with the U.S. Centers for Disease Control and Prevention’s (CDC) Project Firstline, 12 episodes of the Stories of Care podcast about health care equity and infection control, including: Race, Research, and Health Care Associated Infections, Fighting Ableism: What Do You Need?, and Fighting Stigmas Associated With Infectious Diseases. Through October 2023, the Stories of Care podcast had a total of 1,311 downloads and 701 continuing medical education (CME) completions.

  - The AMA continues to partner with the CDC and the Ad Council to encourage the public, with an emphasis on Black and Latinx/Hispanic audiences, to get vaccinated
against influenza (flu). The donated media value for the most recent flu season was about $4.8 million. The public service announcement (as of October 2023) reached 53 percent among Black and 48 percent among Hispanic respondents. We held two media tours in 2023, both in English and Spanish, with spokespeople from AMA and CDC securing nearly 400 placements across TV, radio, and digital.

- The AMA published playbooks and other educational resources for physicians, practices, physician provider organizations, and health systems: as part of STEPS Forward, Wellness-Centered Leadership with a chapter on Racial and Health Equity; and with America's Health Insurance Plans (AHIP) and National Association of Accountable Care Organizations The Future of Sustainable Value-Based Payment: Voluntary Best Practices to Advance Data Sharing, incorporating the promotion of health equity as a key cross-cutting issue (particularly related to health-related social needs) and establishing a specific “best practice category” focused on health equity (“Improve Data Collection and Use to Advance Health Equity”). Additionally, AMA STEPS Forward published a toolkit, Collective Trauma: Respond Effectively as an Organization, and four podcasts focused on social determinants of health and racial and health equity.

- AMA STEPS Forward® hosted the first-ever free in-person Saving Time Boot Camp, intended for Federally Qualified Health Centers (FQHC) staff, offering evidence-based time management strategies to provide quality patient care.

- Private Practice Simple Solutions (PPSS) learning collaboratives were created in support of practices in communities that may lack financial resources to engage with consultants or other external partners.

- The AMA produced six Prioritizing Equity episodes, including: Examining Physician Gender Inequity in Medicine, The SCOTUS Affirmative Action ruling: The Cost to the Physician Workforce and Historically Marginalized Communities, and Advocating for Change in Native Health Policy.

- The AMA provided a detailed internal report to all staff on the first year of cross-enterprise and Business Unit (BU)-specific Equity Action Plans, including some 200 goals across BUs. Leadership approved moving forward with an Embedding Equity dashboard in 2024 starting with the 2020 Employee Equity and Engagement Survey data, moving forward with the next Employee Equity and Engagement Survey (slated to deploy in 2025), and implementing in 2024 the first enterprise-wide equity goals to be included in every BU’s goals, focused on workforce and learning.

- The annual update to the Current Procedural Terminology (CPT) code set for 2024 included Spanish language consumer-friendly descriptors for the first time, which will help CPT users better engage and assist the Latinx community.

- For more than 50 years of the CPT Professional book being published and in circulation, every medical illustration that showed skin tone depicted a white person. In 2023, to address the past exclusion of images that represent the full diversity and identities of the people in our society, the book updated 19 illustrations, including changes to skin tone, facial features, hair, and sex. The 2024 edition updated and diversified 11 illustrations as well as reworked and made additional improvements to three illustrations from 2023. A large diverse group of internal and external reviewers provided feedback prior to publication. There is a three-year plan to update 75-100 more illustrations to depict authentic and diverse illustrations in the over 200,000 copies sold each year.

The AMA’s employee life cycle and internal diversity, equity, and inclusion (DEI) framework help to operationalize DEI initiatives across the enterprise. Within the embedding equity strategic approach, updates on the AMA’s diversity and inclusion strategy included a number of efforts and initiatives:
• Across AMA, hundreds of staff in 2023 engaged in training and educational opportunities with over 60 percent reporting an increase in knowledge, attitudes, skills, or behaviors. Training included the two-day Racial Equity Institute (REI) Phase 1, the Interaction Institute for Social Change (IISC) Facilitative Leadership for Social Change, the Equity & Results Antiracist Results-Based Accountability series, four new skills-based inclusion modules designed, developed, piloted, implemented and evaluated, and Business Unit-specific offerings led by their Health Equity Action Team.

• Individual Business Units have, with the leadership of their respective Health Equity Action Teams, pursued a variety of strategies to operationalize equity: had every team member commit to one of four committees and one goal from their Equity Action Plan, meeting at least monthly; designed and implemented internal monthly reporting to support transparency, dialogue, and decision-making; launched an internal monthly digest to educate colleagues; defined and shared a safe-space framework, rules, and expectations for town hall meetings and issues that arise; implemented community agreements across meetings and incorporated them into a project management playbook (with 79% finding the brave space community agreement beneficial); piloted Racial Healing Circles as a tool for team building across cultural divides; weaved meeting with the Health Equity Action Team about their Equity Action Plan and its progress into the new hire onboarding process; helped clients to consider embedding equity principles throughout projects (e.g., what language is being used, whether the team is diverse, is there a consideration of the project’s impact on minoritized or marginalized communities, and other essential questions); and developed a process to ensure research proposals are evaluated for design bias and equity impact.

• The AMA is analyzing existing IT documentation in shared repositories for identification and removal of racially demeaning terms.

• Starting in 2023, several JAMA Network journals revamped and expanded their editorial fellowship programs to be part-time and fully remote to increase accessibility and inclusivity. The JAMA Network Equity Action Team (JNEAT) established guidelines for staff at every level to understand how to meet individual goals for improving Diversity, Equity, Inclusion, and Belonging – from supporting hiring managers in seeking a diverse candidate base for job openings to providing educational opportunities for staff. JAMA Network DEI editors continued quarterly discussions within their individual journals. The team will be publishing results of an inter-departmental survey of editors and editorial boards that highlight staff demographics, including self-identified gender, race, and ethnicity.

• The AMA made its offices more equitable, installing privacy strips in the restrooms, stocking menstrual supplies in all restrooms, facilitating hybrid meetings with necessary accommodations, and installing or ordering sit/stand desks and other ergonomic office equipment. The organization continues to work towards ensuring AMA offices are accessible for differently abled individuals.

Build Alliances and Share Power

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

• AMA’s sponsorship plan reflected outreach to diverse audiences, including The National LGBTQ+ Journalists Association (NLGJA) and Asian American Journalists Association (AAJA) Journalists conferences.
• Three new health equity-oriented content partners were signed to AMA’s Ed Hub: Docs with Disabilities, Radiology Health Equity Coalition (RHEC), and UCSF Center for Climate Health Equity. The AMA collaborated with HealthBegins to launch six modules of Upstream Training and Education.

• To further leverage existing resources and partnerships, AMA participated in four meetings with the Association of American Medical Colleges (AAMC) and the Accreditation Council for Graduation Medical Education (ACGME) about diversifying the physician workforce; attended three ACGME Diversity Officers Forums; delivered two webinars (Removing barriers and facilitating access: Supporting trainees with disabilities across the medical education continuum and Enhancing Diversity Among Academic Physicians: Recruitment, Retention and Advancement), two presentations to Academic Physicians Section on equity, diversity and belonging focused on medical education and minoritized physician burnout and wellbeing, and three presentations on the implications of the Supreme Court (SCOTUS) decision of Students for Fair Admissions v. Harvard University and the University of North Carolina at Chapel Hill; and completed a review of configurative mapping on diversity in medical education.

• Continuing its work around physician workforce data, the AMA is collaborating with the AAMC and the ACGME to establish a common understanding for the categorization, reporting, and sharing of sociodemographic data, beginning with race and ethnicity. This collaborative completed a study and is finalizing a guide on the addition of the Middle Eastern North African (MENA) category, identifying best practices in aggregation and reporting. Categorization has been provided by the AMA to the American Board of Medical Specialties, Federation of State Medical Boards, Council for Affordable Quality Healthcare, Massachusetts Medical Society, and Workgroup for Electronic Data Interchange health equity work group. MedBiquitous, a standards development organization in the academic medicine space, has expressed interest in adopting the categorization being developed by the collaborative in lieu of creating their own.

• The AMA, alongside AHIP, the Alliance of Community Health Plans, the American Hospital Association, and Kaiser Permanente, launched the Common Health Coalition: Together for Public Health. The coalition is focused on translating the hard-won lessons and successes of the COVID-19 pandemic response into actionable strategies that will strengthen the partnership between our health care and public health systems. In 2024, the coalition will publish recommendations informed by technical advisory groups of subject matter experts and an advisory council of public health leaders, focused on four initial priority areas: spearheading greater coordination between the public health and health care systems; building shared, well-maintained emergency preparedness plans; establishing national standards for health care data that help identify health disparities; and modernizing infectious disease detection.

• AMA continues to work in partnership with the March of Dimes (MOD) and has contracted with MOD and Sinai Urban Health Institute to identify the impact of facility closures and loss of services on the South and West side of Chicago, with the goal of producing a final report in 2024. AMA aims to continue its engagement with and participation in the MOD workgroups (Dismantle Racism, Increasing Access to Care, and Engage Communities).

• AMA staff continue to volunteer locally and build meaningful relationships with community organizations. The Enterprise Social Responsibility (ESR) team has aligned with the health equity strategic framework by valuing and uplifting the variety and diversity of work and careers that address social determinants of health and contributes to wellness. ESR piloted a co-design process with three community partners to develop a signature service model to address emerging community needs while aligning with AMA’s mission and equity goals. ESR identified and hosted about 35 community engagement opportunities to build healthy, thriving, equitable communities, including My Block, My Hood, My City; Gardeneers; and the Erie House.

• The second cohort of the Medical Justice in Advocacy Fellowship, an educational initiative in collaboration with Morehouse School of Medicine’s Satcher Health Leadership Institute,
culminated at the Interim meeting of the House of Delegates, where 11 physician leaders were celebrated and presented their health equity project concepts.

- The AMA launched its inaugural Summer Health Law Internship, an eight-week paid summer internship program for a third year or master’s law student to learn more about health equity and health law; continued working with The Urban Alliance by hosting a summer internship program that exposes Chicago students to medical publication to provide career exposure; hired a summer intern from Chicago Public Schools in Finance; and partnered with University of Chicago's Youth Internship Program, hosting an onsite a panel discussion with 23 IT-interested high school students, and are exploring further IT mentoring opportunities.

- The AMA completed a total of 32 burnout assessments with FQHCs and/or community health centers, all organizations serving patients from predominantly historically marginalized communities. Twenty of the 32 assessments were conducted for the organizations in the Arizona Alliance, a consortium of FQHCs, as well as several virtual workshops and reporting sessions to provide insight into interventions to reduce medical staff burnout. Several participating FQHCs were recognized through the AMA’s Joy in Medicine™ Health System Recognition Program.

- Minority and/or woman owned businesses were identified and recommended for several projects, including one with an estimated value in excess of $250,000. Additionally, three West Side United (WSU) vendors were recommended for requests for proposals with more than $700,000 spent with Local Vendors reported in monthly WSU Anchor Partner meetings. The AMA released a DEI survey to professional services vendors with material levels of spending in 2023 to collect information about the vendors and their policies regarding marginalized populations and DEI.

- The AMA set a five-year goal to scale and improve programs to five million patients diagnosed with hypertension (HTN) to achieve a 10 mm Hg drop in systolic blood pressure (SBP) or reach BP goal, and one million patients identifying as Black, Latina/e/o/x/Hispanic, Asian, Indigenous, and other historically marginalized groups. As of the end of 2023, approximately 71,723 patients had been impacted, with 51 percent from historically marginalized populations. This number includes patients from two large health care organizations located in the West Side of Chicago. Additionally, the AMA initiated projects to embed and advance equity within its AMA MAP HTN™ program to better understand the impact of the program on historically marginalized populations and identify opportunities to reduce inequities.

**Push Upstream**

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

- AMA continues to embed equity in its state and federal advocacy work and continues to elevate this and other equity-related work accomplished among AMA members and Federation Societies. Equity-related policy priorities can be seen throughout the AMA’s engagement with Congress, the Administration, state legislatures, and other policymakers, in the form of advocacy letters, presentations and testimony to state legislatures, national and medical organizations, and countless additional opportunities that engaged organized medicine and policymakers. In 2023, the AMA continued to actively voice support for:
  - International medical graduates (IMGs);
  - Deferred Action for Childhood Arrivals (DACA) recipients;
  - Migration and refugee population health and safety;
  - Nutrition programs expansion and culturally respectful dietary guidelines;
  - Medicaid coverage expansion;
In late May, in partnership with Institute for Healthcare Improvement (IHI), and in collaboration with Race Forward, HealthBegins, Groundwater Institute, and a variety of other organizations, the AMA formally announced the launch of Rise to Health: A National Coalition for Equity in Health Care. The goal of the Rise to Health Coalition is to bring together individuals and organizations across five key audiences (pillars) including: individual practitioners, health care organizations, professional societies, payers, and pharma, research, biotech organizations, to advance health equity by identifying shared solutions, common frameworks, and best practices for spread and scale.

The AMA continues to publish highly engaging health equity content on the AMA Ed Hub site with 176 activities published in 2023. Uptake of equity content in 2023 far exceeded 2022, with 213,982 engagements (compared to 161,189) and 53,117 course completions (compared to 32,453). Four National Health Equity Grand Rounds sessions were held, which brought 10,189 registrations (8,254 new registrants) to the Ed Hub site: The History of Racism in US Health Care; Follow the Money; Breaking Down the Ivory Tower; and Creating Accountability Through Data. Each session was designed to maximize accessibility for viewers.

The AMA is a founding member of The Gravity Project, a Health Level 7 Fast Healthcare Interoperability Resources Accelerator focusing on social determinants of health (SDOH) data interoperability. The AMA contributes funding and staff time, for leadership and co-development of the SDOH terminology and data exchange standards. The newly released White House “US Playbook to Address Social Determinants of Health” for federal initiatives recognized the Gravity Project throughout the document. The AMA provided education to physicians on the utility of CPT codes to document and provide services based upon identified SDOH.

Ensure Equity in Innovation

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

- The AMA continues to strive toward the adoption, optimization, and sustainability of responsible, impact and equitable digitally enabled innovations. This includes highlighting organizations that...
are championing and implementing health equity on the Physician Innovation Network (PIN) and providing a place for the Principles of Equitable Innovation to engage in important conversations through PIN. The AMA connected stakeholders and fostered collaboration to improve the development, evidence base, and quality of digital health solutions.

- The AMA’s In Full Health initiative, in collaboration with The New Voices Foundation, provided five microgrants to Black healthcare/health tech entrepreneurs to attend The New Voices Foundation Health Innovator Hub at ESSENCE Festival 2023. The Black health innovators created solutions through tech, community partnerships, and medicine – building businesses that meet critical needs in the Black community and advance health equity. The healthcare/health tech entrepreneurs exhibit at the Innovator Hub at the ESSENCE Festival, which is visited by over 500,000 people each year.

- At the May CPT Editorial Panel Meeting, they approved adding eight questions to the CPT Code Change Application to help the Panel make informed decisions about AI CPT applications and apply the AI Taxonomy (Appendix S in the CPT Code Set) consistently. One question asks the applicant to explain how bias factors into the algorithm data.

Foster Truth, Racial Healing, Reconciliation, and Transformation

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

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

Challenges and Opportunities

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

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

CONCLUSION

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

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

AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

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

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

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

At the heart of the AMA’s unwavering commitment to reforming the Medicare physician payment system lie four central pillars that underscore our strategic approach: legislative advocacy, regulatory advocacy, federation engagement, and grassroots, media, and outreach initiatives. Grounded in principles endorsed by a unified medical community, our legislative efforts drive the advancement of policies that foster payment stability and promote value-based care. We actively champion reform through regulatory channels, tirelessly engaging with crucial agencies such as the Centers for Medicare & Medicaid Services (CMS) and the White House to address impending challenges and ensure fair payment policies. Our federation engagement fosters unity and consensus.
within the broader medical community, pooling resources and strategies to amplify our collective voice. Lastly, our continued grassroots, media, and outreach efforts bridge the gap between policymakers and the public, ensuring our mission is well-understood and supported from all quarters. Together, these pillars fortify our endeavors to achieve a more rational Medicare physician payment system that truly benefits all.

Legislative Advocacy

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

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

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

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

H.R. 5013/S. 3503, the Value in Health Care (VALUE) Act, introduced on July 28, 2023 by Reps. Darin LaHood (R-Ill.) and Suzan DelBene (D-Wash.) in the House and Senators Whitehouse (D-R.I.) and Barrasso (R-Wyo.) in the Senate on December 13, 2023, would extend the 5 percent APM bonus and maintain the 50 percent revenue threshold required for the bonuses. In November of 2023, the Senate Committee on Finance and the House Committee on Energy and Commerce advanced legislation to offset a portion (1.25 percent) of the 2024 CF cuts as well as to partially extend the APM bonus and maintain the current revenue threshold required for the bonuses. During these markups, members of both committees discussed the need for Medicare payment reform at length and secured pledges from the chairs to address the issue in earnest in 2024.

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

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

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

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

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

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

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

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

The AMA is also in the process of finalizing legislative language that would: (1) simplify MIPS reporting and improve its clinical relevance; (2) reduce the potential severity of penalties (currently as much as -nine percent) for those scoring poorly under MIPS; (3) provide support to smaller practices that tend to score lower under the program; and (4) provide timely and meaningful performance feedback to physicians and expand the use of clinical data registries.
In addition to regular interactions with members of Congress and their staff by Advocacy staff, the AMA has sent a number of letters and statements to Capitol Hill, including the following:

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

**Regulatory Advocacy**

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

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

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

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

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

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

**Federation Engagement**

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

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

**Grassroots, Media, and Outreach**

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

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

**2023 Fix Medicare Now Campaign Top Line Results**

- 425,900+ FixMedicareNow.org Page views
- 173,60000+ FixMedicareNow.org Site Visitors
- 40,679,400+ Impressions
- 498,000+ Engagements
- 1,200+ #FixMedicareNow Social Media Mentions
- 450+ FixMedicareNow.org Advocacy Hub User Submissions
- 288,000+ Contacts to Congress
Message testing of arguments made in support and opposition to Medicare payment reform was completed in late 2023. Focus groups of U.S. voters were conducted in June, and a national poll was launched in late July. The results of this message testing have been utilized to refine language used in earned and paid media, as well as patient grassroots outreach.

**CONCLUSION**

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

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

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

Please follow Advocacy Update, join the Physicians Grassroots Network, visit [www.FixMedicareNow](http://www.FixMedicareNow) often for updated material and alerts, and follow other AMA communications vehicles to stay up to date and engaged on this topic.
At the 2023 Annual Meeting of the House of Delegates (HOD), the HOD adopted Resolution 015 - A-23 entitled, “Report Regarding the Criminalization of Providing Medical Care,” which instructed the American Medical Association (AMA) to:

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

This report is submitted for the information of the HOD.

BACKGROUND

Abortion

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

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

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

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

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

Risk-averse hospitals and institutional policies are also likely to contribute to changes in medical practice. In May 2023, the Centers for Medicare & Medicaid Services announced investigations into two Missouri hospitals that allegedly withheld necessary stabilizing care to a pregnant patient experiencing preterm premature rupture of membranes in violation of the Emergency Medical Treatment and Labor Act. The government’s announcement stated that, in one situation, although the patient’s doctors advised her that her pregnancy was no longer viable and her condition could rapidly deteriorate, they could not provide her with the care that would prevent infection, hemorrhage, and potentially death due to hospital policies. Physicians have described other similar hospital policies in which non-clinicians determine whether and at what point abortion care may be provided.
Though abortion bans may be altering the treatment of pregnancy complications, available data indicate that abortion bans have not reduced the total number of abortions provided but have shifted the geographic distribution of abortion care. The #WeCount initiative led by the Society for Family Planning reported that from July 2022 to June 2023 the number of clinician-provided abortions increased modestly, with a monthly average of 82,115 abortions before the Dobbs decision and a monthly average of 82,298 in the 12 months after the Dobbs decision. As anticipated, states with abortion bans reported significant declines in the number of abortions provided after Dobbs, with 14 states experiencing a 100 percent decrease. Accordingly, the number of live births has risen in places that ban abortion. Research published in November 2024 estimated that, in the first six months of 2023, births rose by an average of 2.3 percent in ban states compared to states where abortion remained legal. The authors estimated that roughly one-fifth to one-fourth of people seeking abortions did not receive them due to bans. Another study from the Johns Hopkins Bloomberg School of Public Health estimated that nearly 9,800 additional live births occurred in Texas in the year after the state’s abortion ban took effect.

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

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

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

Gender-affirming Care for Minor Patients

As of the writing of this report in March 2024, 23 states have enacted bans on gender-affirming care for minor patients. Twenty-one states (Alabama, Arkansas, Florida, Georgia, Iowa, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Montana, Missouri, North Carolina, North Dakota, Ohio, Oklahoma, South Dakota, Tennessee, Texas, Utah, and West Virginia) broadly prohibit the provision of gender-affirming care to minor patients, including medications to delay puberty, hormonal therapy, and surgeries. Two states (Arizona and Nebraska) prohibit surgical interventions on patients younger than 18 years of age but do not ban non-surgical interventions. Legislative prohibitions on gender-affirming care have been relatively recent developments. The Arkansas legislature enacted the first such law in 2021, followed in 2022 with legislation in Alabama and Arizona and administrative action in Florida and Texas. Twenty-two states then enacted bans in 2023 and 2024.
Among the 23 states that prohibit providing gender-affirming care to minors, some, but not all, impose criminal penalties for violations. In other states, violations are subject to professional discipline, including, in some places, mandatory revocation of the health care professional’s license. Several state laws also authorize patients and their families to bring civil suits against health care professionals for decades after the care was provided.

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

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

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

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

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

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

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

DISCUSSION

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

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

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

2. Practice management, including developing recommendations and educational materials
   for addressing reimbursement, uncompensated care, interstate licensure, and provision of
care, including telehealth and care provided across state lines;
3. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;

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

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

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

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

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

CONCLUSION

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

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.
Subject: AMA Public Health Strategy: Update

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

BACKGROUND

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

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

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

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

DISCUSSION

What is Public Health?

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

Connection with Health Equity

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

AMA PUBLIC HEALTH AND PREVENTION ACTIVITIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- The first phase (2021-2023) of the Action Collaborative’s work has been focused on identifying key opportunities and challenges to climate action, decarbonization, and building resiliency across the health sector and developing resources and tools to meet those needs. The collaborative, through the work of the members have completed over thirty resources to accelerate climate action across the health sector.

- The second phase (2024-2025) will consist of accelerating a national climate and health movement, as well as advancing the successes of the existing working groups and launching an accelerator pilot program.

The AMA is represented on the APHA Center for Climate, Health, and Equity Advisory Board. In February 2024, the Advisory Board organized a roundtable of public health experts to discuss the health, climate and equity priorities for consideration of the reauthorization of the federal transportation bill, which is scheduled to be renewed in 2025.

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

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

- A letter to Environmental Protection Agency (EPA) on their proposed ruling regarding Pollutant Emissions Standards for Model Years 2027 and Later Light- Duty and Medium-Duty Vehicles, urging them to pass the most stringent emission standards possible with existing technologies.

- A letter to EPA on their proposed ruling regarding National Emission Standards for Hazardous Air Pollutants: Coal- and Oil-Fired Electric Utility Steam Generating Units Review of the Residual Risk and Technology Review.

- A letter to EPA on their proposed ruling in the Reconsideration of the National Ambient Air Quality Standards for Particulate Matter, calling for the most protective standards to protect the health of the most vulnerable populations. To note, EPA finalized their particulate matter rule on February 7, 2024. While the new rule did not set particulate matter at the more protective standard as advocated for by the Healthy Air Partners group, the revised rule did address several of our comments and the new standards will result in significantly reduced particulate matter pollution in the future.

- A letter to EPA on their draft Revised Technical Guidance for Assessing Environmental Justice in Regulatory Analysis, which included the addition of climate change as a factor of vulnerability when conducting environmental justice analysis.

B. Prevent firearm injuries and deaths.

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

- The AMA is participating in the Health Professional Education and Advocacy/Policy committees of the Healthcare Coalition for Firearm Injury Prevention, which is being led by American Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEP), American College of Physicians (ACP), American College of Surgeons (ACS), and the Council of Medical Specialty Societies (CMSS).21

- On October 25–26, 2023, Alexander Ding, MD, MS, MBA, represented the AMA at the Milken Institute’s Innovation Forum on Preventing Gun Violence in San Francisco. This first-of-its-kind convening explored how technologies, expanded community collaboration, and innovative models could unlock real progress to prevent gun violence and address its societal repercussions.

- On December 14, 2023, the AMA convened the Firearm Injury Prevention task force for an in-person meeting held at AMA Headquarters in Chicago. Willie Underwood, MD, MSc, MPH, Chair of the AMA Board of Trustees and the task force led the meeting along with task force Co-Vice Chairs Toluwalasé (Lasé) Ajayi, MD, and Alexandar Ding, MD, MS, MBA. Representatives to the task force discussed their organization priorities on firearm injury prevention, examined the possibility of creating a resource center on firearm injury prevention for physicians that would include information for patients and resources on evidence-based interventions, and discussed the development of a toolkit for physicians on extreme risk protection orders.

- On February 7, 2024, the AMA was represented by Willie Underwood, MD, MSc, MPH, at the Northwell Health’s Gun Violence Prevention Forum in New York City.

- On March 4, 2024, the AMA convened a virtual meeting of the Firearm Injury Prevention task force, where the members had the opportunity to hear from the Ad Council both about their ongoing gun violence work as well as their new campaign, funded by members of the National Health Care CEO Council on Gun Violence Prevention and Safety. The new campaign seeks to elevate the issue of gun violence in America and its impact on youth, shifting away from divisive, politically charged conversations to those focused on public health approaches that have proven effective in combating this epidemic.

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

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

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

- Legislative Document (LD) 2237 - An Act to Strengthen Public Safety, Health and Well-being by Expanding Services and Coordinating Violence Prevention Resources. AMA policy supports many of the initiatives in this comprehensive legislation, and applauds the
investment in violence prevention strategies, access to behavior health services, suicide prevention, and crisis intervention programs. (Policies H-145.975, D-345.972, H-345.972, and H-60.937)

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

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

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

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

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

Infectious diseases continue to evolve and advance throughout the U.S. Pathogens that were once geographically limited are now advancing beyond those traditional borders. Blastomycosis, Histoplasmosis and Coccidioidomycosis are all fungal infections that have pushed past expected boundaries. In addition to organisms known to be found in the U.S., tropical diseases like malaria, dengue and Leishmaniasis have all been found in the U.S. in nontravelers. Re-emerging pathogens like measles continue to find footholds across the country. While it’s unclear what the next infectious diseases outbreak will bring, the U.S. health system must be ready. Because the AMA is relied upon as a source of information by physicians and patients, the AMA must maintain the ability to respond and share information and advocate for physicians, patients, and the public in line with AMA policies.
The AMA is a collaborator in Project Firstline, the CDC’s National Training Collaborative for Healthcare Infection Control. Project Firstline offers educational resources in a variety of formats to meet the diverse learning needs and preferences of the health care workforce.23

- Over the last year, AMA has developed 10 Stories of Care podcast episodes exploring inequalities in infection prevention and control (IPC). The podcast series is hosted by Megan Srinivas, MD, MPH, and has featured episodes on IPC Challenges in Rural Health Care; Race, Research, and Health Care Associated Infections; TB or Not TB: Caring for a Special Population; Fighting Ableism: What Do You Need?; The Hidden Inequities of Dialysis-Related Infections; and Partners in Care: Environmental Services on the Front Line.

- The AMA provided funding to 7 state and specialty medical societies to develop training and IPC content for the membership and disseminate Project Firstline content.

- The AMA has partnered with the CDC on webinars addressing re-emerging pathogens and the end of the COVID-19 public health emergency.

- On December 12, 2023, Sandra Fryhofer, MD, hosted a fireside chat to discuss vaccinations and other tools that can keep everyone safer against influenza, COVID-19, and respiratory syncytial virus (RSV) this respiratory virus season. Participants included CDC Director Mandy Cohen, MD, MPH and Demetre Daskalakis, MD, MPH.

- The AMA hosted a five-part webinar series with the CDC on its Hospital Sepsis Program Core Elements, which offer guidance to help clinicians, hospitals and health systems implement, monitor and optimize their sepsis programs and outcomes. The series included real-life examples, strategies and best practices and offers continuing education credit.

- A tele-mentoring series will kick off in April of 2024 that will explore the nuances of infection prevention in facility types outside of the acute care hospital. Settings will include acute rehabilitation hospitals, ambulatory surgery centers, behavioral health units, post-acute long-term care facilities, dialysis facilities, and pediatric units.

- A CME module is under development that will present patient cases outlining transmission-based precautions so that physicians and other health care professionals can recognize how to protect themselves in any situation.

D. End the nation’s drug overdose epidemic.

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

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

- In 2023 the AMA worked to update content and resources for the physician education series of module Practical Guidance or Pain Management. This content was made available to help physicians meet the DEA’s MATE Act requirements.
• The AMA continues to convene the Substance Use and Pain Care Task Force, which supports and guides the development of the annual Overdose Epidemic Report on the overdose epidemic outlining current data, policy, updates, clinical accomplishments and what still needs to be done.25

• In 2023, the AMA developed physician education podcast series on *The Opioid Overdose Epidemic*. Hosted by Bobby Mukkamala, MD, Chair of the Substance Use and Pain Care Task Force, episodes feature experts who shared relevant research, insights, and experience to help physicians of all specialties in addressing the opioid overdose epidemic. As of November 2023, the podcast episode course completions have shown a high interest in the topics, which include: *Opioid Prescribing and Appropriate Pain Management, Opioid Overdose Prevention, and Opioid Use Disorder Treatment.*

• The AMA is planning additional episodes as a part of this series for 2024, which will consist of four episodes including: *Opioid Use Disorder and Pregnancy, Opioid Utilization in Hospice and Palliative Care, Disparities in Access to Medication for Opioid Use Disorder, and Opioid Use a Prevention Approach.*

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

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

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

• In November 2023, AMA and health care partners announced the Common Health Coalition: Together for Public Health, a partnership between AMA and four other leading healthcare organizations, including: AHIP (formerly America’s Health Insurance Plans), Alliance of Community Health Plans (ACHP), American Hospital Association (AHA), and Kaiser Permanente (KP).26 The Common Health Coalition is focused on translating the hard-won lessons and successes of the COVID-19 pandemic response into actionable strategies that will strengthen the partnership between our health care and public health systems.

• On March 13, 2023, the Common Health Coalition announced a set of commitments that will better equip U.S. health care organizations to collaborate with public health systems in preparing for the next public health emergency. Dave Chokshi, MD, MPH, Chair of the Coalition announced the commitments at the Politico Health Summit. The Coalition's founding members, including the AMA, committed to action in four priority areas:
  - 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/](https://commonhealthcoalition.org/).

• On April 11, 2024, the AMA was represented on a panel at the KP Health Summit in Washington, D.C., focused on *Building a Strong Public Health Ecosystem*. This session
explained the commitments the Coalition has made and actions each organization will take to create a strong public health system and healthier future for all.

4. Combat the spread of misinformation and disinformation.

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

- The Coalition for Trust in Health & Science’s vision is for all people to have equitable access to accurate, understandable, and relevant information to make personally appropriate health choices and decisions. The AMA is an active member, engaging with leadership and participating in programming.

- The AMA is also an active participant in the Mitigating Medical Misinformation Workgroup and supported its recent research that found primary care physicians were viewed as the most trusted source for medical information. The AMA will work with this group to disseminate these findings to a broader audience in 2024 and will continue to coordinate efforts internally to ensure alignment.

- The AMA filed an amicus brief with the U.S. Supreme Court in the case of Murthy v. Missouri. The brief focuses on how disinformation diminished uptake of COVID-19 vaccines, which then limited the vaccines’ ability to save lives by controlling the spread of disease—thereby creating a compelling interest for the government to act. The high court will hear oral arguments in the case on March 18, 2024.

CONCLUSION

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


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

BACKGROUND

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

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

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

DISCUSSION

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

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

Providing a Voice for Independent Physicians in the HOD and Beyond

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

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

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

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

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

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

**Outreach to Independent Physicians**

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

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

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

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

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

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

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

CONCLUSION

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

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

Resolution 606 asked:

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

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

BACKGROUND

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

Costs

A fiscal note of $8.1 million was the estimate of the ongoing additional annual costs that would be incurred by the AMA if this resolution were adopted. This would be in addition to the $12 million the AMA is spending already to hold HOD meetings and provide staff support for councils,
sections and special groups. That does not include costs related to responding to and implementing resolutions from the HOD.

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

**AMA Budget and Reserve Policies**

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

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

**Financial and Tax Implications**

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

Additional discussions with tax counsel have resulted in another potential alternative, i.e., providing travel grants to societies in the HOD to cover or partially cover direct out-of-pocket expenses for delegates and alternate delegates based on financial need. Under this alternative, counsel recommended the following criteria: 1) the travel grants be limited to societies that demonstrate financial need; 2) the travel grants should be specifically identified as grants to cover travel reimbursement only for voting delegates and alternate delegates who participate in the HOD meetings, enabling delegates to participate in discussions regarding important issues affecting AMA and the medical profession; 3) the grant agreement between AMA and the society should
require that the funds are for reimbursement of incurred travel expenses in a manner that is consistent with 501(c)(6) purposes; and 4) that AMA should establish a cap on the amount that any one society can receive for reimbursement of travel expenses.

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

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

The AMA realizes the importance of representation and participation in the policy-making process and the strength of organized medicine, are the organizations who send representatives to our HOD meetings to participate in the policy making process. Your Board of Trustees presents this report as informational as we continue to study options for strengthening the participation of the Federation in House of Delegates meetings. Your Board will submit a report at the 2025 Annual Meeting.
At the 2023 Annual Meeting, the House of Delegates referred Resolution 007, “Independent Medical Evaluation,” to the Board of Trustees. Resolution 007 specifically asked:

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

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

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

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

PURPOSE AND DEFINITION OF INDEPENDENT MEDICAL EVALUATIONS (IME)

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

The goal of the IME physician is to provide an unbiased, evidence-based assessment regarding the individual’s medical status, including the nature and extent of injuries or disabilities. During an IME, the examinee’s relevant medical history, current condition, test results, functional status, and any relevant medical records are assessed. The AMA Guides to the Evaluation of Permanent Impairment (AMA Guides) provide a reliable measurement framework for assessing permanent impairment and are required in many jurisdictions.¹² An impairment rating may be a component of
the IME, which is defined as a “consensus-derived percentage estimate of loss of activity, which reflects severity of impairment for a given health condition, and the degree of associated limitations in term of Activities of Daily Living (ADLs)”. The AMA Guides Editorial Panel ensures the AMA Guides are up to date with the latest evidence-based medicine and science.

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

Common Scenarios for IMEs

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

PROFESSIONAL QUALIFICATIONS FOR INDEPENDENT MEDICAL EVALUATORS

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

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

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

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

Objectivity and Bias

The IME process should be objective, independent and unbiased with the substantiation of findings and recommendations based upon available information and evidence.3,4 Physician transparency in
reporting and testimony can reinforce impartiality. Having IMEs performed in a timely manner in
an appropriately situated and appointed environment is in the best interest of the examinee and
involved parties. However, there may be conflicts of interest to consider.

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

While practicing in these roles, physicians have dual responsibilities to both the patient and the
employer or third party. However, there is also the additional duty to uphold the obligations of a
medical professional. Therefore, the following should be considered:[^5]

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

**PROTECTIONS FOR THE EXAMINEE**

**Informed Consent**

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

Additional best practices for the informed consent process are as follows:[^4]

- Discuss the importance of the examinee’s reading and signing of a written informed
  consent with the examinee prior to the evaluation.
- Establish the ground rules for the performance of the service.
- Provide the opportunity for the examinee to understand the rationale for the IME, who is
  requesting the evaluation, and where the report will be sent.
- Ensure the examinee understands what the IME provider can and cannot do.
- Acknowledge that the examinee understands that there will be no physician-patient
  relationship established.
- Confirm that there will not be a discussion regarding diagnoses nor any recommendations
  for treatment.
- Indicate that the examinee is consenting to having their history taken and that an
  examination will occur.
- Clearly state that the IME physician is independent and that any opinions developed are
given irrespective of anyone else involved in the claim (a third-party evaluation).
• State that there is an understanding that the results of the evaluation (the report) will only be given to the requesting party (unless there is a jurisdictional rule that requires something else).
• Spend an appropriate amount of time on the informed consent process to ensure that the IME physician can answer questions or clarify points that are not well understood.

**IME Report Access**

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

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

**Third-Party Observation**

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

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

**PROTECTIONS FOR PHYSICIANS**

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

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

In addition to examinee rights, the following list outlines best practices for minimizing professional risks for physicians conducting IMEs:
• Detailed record-keeping of the IME process, findings, and the basis for conclusions to safeguard against potential disputes or allegations of misconduct. Documentation should be clear, factual, and free of any speculation.

• Safeguarding all IME-related documents and records, including during transport.

• Clear, professional communication with all parties involved. This includes the ability to explain medical terms and findings in layman's terms, which can reduce misunderstandings and conflicts.

• Only performing IMEs in their respective area of specialty and board certification. If an examination or interpretation of findings falls outside expertise, consult with other specialists.

• Having appropriate professional liability insurance that covers IMEs to provide financial and legal protection in case legal claims arise.

• Staying informed about the latest developments and any changes in laws or guidelines related to IMEs to avoid practices may cause exposure to liability.

• Seeking advice, when in doubt, on complex issues related to IMEs from legal professionals or a professional association.

• Identifying, disclosing and avoiding conflicts of interest, such as evaluating family members.

• Taking precautions disclosing information to third parties, limiting it to the minimum necessary for the intended purpose and remove individually identifying information before releasing aggregate data or statistical health information.6

STRUCTURAL BARRIERS IMPACTING 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.
REFERENCES

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

INTRODUCTION

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

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

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

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

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

DATA SOURCES

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

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

Some key considerations must be kept in mind regarding the information captured in this report. Vacancies in delegation rosters mean that the total number of delegates is less than the 705 allotted
at the November 2023 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. As such, the total number of delegates and alternate delegates is 1091 rather than the 1410 allotted. Race and ethnicity information, which is provided directly by physicians, is missing for approximately 15 percent of AMA members and approximately 19 percent of the total United States physician and medical student population, limiting the ability to draw firm conclusions. Efforts to improve AMA data on race and ethnicity are part of Policy D-630.972. Improvements have been made in collecting data on race and ethnicity, resulting in a decline in reporting race/ethnicity as unknown in the HOD and the overall AMA membership.

CHARACTERISTICS OF AMA MEMBERSHIP AND DELEGATES

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

Data on physicians’ and students’ current activities appear in Table 2. This includes life stage as well as present employment and self-designated specialty.

| Table 1. Basic Demographic Characteristics of AMA Members & Delegates, December 2023 |
|------------------------------------------|------------------------------------------|------------------------------------------|
|                                         | 2023 AMA Members | All Physicians and Medical Students | AMA Delegates & Alternate Delegates 1,2 |
| Total                                    | 282,952          | 1,514,092                           | 1,091                                    |
| Mean Age (Years)                         | 46.7             | 52.8                                 | 54.2                                     |
| Age                                       |                  |                                      |                                          |
| Under Age 40                              | 52.9%            | 30.5%                                | 19.1%                                    |
| 40-49 Years                               | 11.1%            | 17.2%                                | 18.1%                                    |
| 50-59 Years                               | 9.5%             | 15.8%                                | 20.2%                                    |
| 60-69 Years                               | 9.0%             | 15.6%                                | 25.8%                                    |
| 70 or More                                | 17.5%            | 20.8%                                | 16.9%                                    |
| Gender                                    |                  |                                      |                                          |
| Male                                      | 58.9%            | 61.9%                                | 60.8%                                    |
| Female                                    | 40.5%            | 37.2%                                | 39.0%                                    |
| Unknown                                   | 0.6%             | 0.9%                                 | 0.2%                                     |
| Race/Ethnicity                            |                  |                                      |                                          |
| American Indian or Alaskan Native         | 0.17%            | 0.17%                                | 0.2%                                     |
| Asian                                     | 17.5%            | 16.7%                                | 14.8%                                    |
| Black or African American                 | 5.3%             | 4.5%                                 | 5.8%                                     |
| Hispanic                                  | 4.1%             | 4.5%                                 | 3.3%                                     |
| Mixed Race/Ethnicity                      | 5.8%             | 4.0%                                 | 3.1%                                     |
| Native Hawaiian or Other Pacific Islander | 0.05%            | 0.04%                                | 0.0%                                     |
| White                                     | 50.4%            | 49.9%                                | 62.9%                                    |
| Unknown                                   | 14.9%            | 18.5%                                | 8.3%                                     |
| Other                                     | 1.8%             | 1.7%                                 | 1.6%                                     |
| Education                                 |                  |                                      |                                          |
| US or Canada                              | 81.3%            | 77.2%                                | 90.6%                                    |
| IMG                                       | 18.7%            | 22.8%                                | 9.4%                                     |

1 There were 319 vacancies as of year’s end.
2 Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
3 Age as of December 31. Mean age is the arithmetic average.
4 Includes other self-reported racial and ethnic groups.
<table>
<thead>
<tr>
<th>Life Stage</th>
<th>2023 AMA Members</th>
<th>All Physicians and Medical Students</th>
<th>AMA Delegates &amp; Alternate Delegates 1,2</th>
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<tbody>
<tr>
<td>Student</td>
<td>18.2%</td>
<td>7.7%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Resident</td>
<td>29.0%</td>
<td>11.5%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Young (under 40 or first 8 years in practice)</td>
<td>10.0%</td>
<td>15.3%</td>
<td>6.5%</td>
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<tr>
<td>Established (40-64)</td>
<td>20.8%</td>
<td>36.7%</td>
<td>49.9%</td>
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<td>Senior (65+)</td>
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<th>Present Employment</th>
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<tr>
<td>Self-Employed Solo Practice</td>
<td>5.8%</td>
<td>7.2%</td>
<td>10.5%</td>
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<tr>
<td>Two physician practice</td>
<td>1.3%</td>
<td>1.7%</td>
<td>1.6%</td>
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<tr>
<td>Group practice</td>
<td>23.5%</td>
<td>38.9%</td>
<td>38.5%</td>
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<tr>
<td>HMO</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Medical School</td>
<td>0.8%</td>
<td>1.3%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Non-government hospital</td>
<td>3.0%</td>
<td>4.2%</td>
<td>8.2%</td>
</tr>
<tr>
<td>State or local government hospital</td>
<td>3.4%</td>
<td>5.6%</td>
<td>10.4%</td>
</tr>
<tr>
<td>US government</td>
<td>0.8%</td>
<td>1.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Locum Tenes</td>
<td>0.1%</td>
<td>0.2%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Retired/Inactive</td>
<td>11.0%</td>
<td>12.8%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Resident/Intern/Fellow</td>
<td>29.1%</td>
<td>11.6%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Student</td>
<td>18.3%</td>
<td>7.8%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>2.8%</td>
<td>7.1%</td>
<td>3.6%</td>
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<table>
<thead>
<tr>
<th>Specialty</th>
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<tbody>
<tr>
<td>Family Medicine</td>
<td>7.9%</td>
<td>10.3%</td>
<td>10.8%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>21.0%</td>
<td>22.8%</td>
<td>20.3%</td>
</tr>
<tr>
<td>Surgery</td>
<td>12.8%</td>
<td>12.8%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>5.5%</td>
<td>8.6%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynecology</td>
<td>4.9%</td>
<td>4.4%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Radiology</td>
<td>3.4%</td>
<td>4.3%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>4.4%</td>
<td>5.1%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>3.5%</td>
<td>4.4%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Pathology</td>
<td>1.7%</td>
<td>2.2%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Other Specialty</td>
<td>16.6%</td>
<td>17.4%</td>
<td>17.0%</td>
</tr>
<tr>
<td>Students</td>
<td>18.2%</td>
<td>7.7%</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

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5 See Appendix for a listing of specialty classifications.
6 Students and residents are categorized without regard to age.
Appendix

Specialty classification using physician’s self-designated specialties.

<table>
<thead>
<tr>
<th>Major Specialty Classification</th>
<th>AMA Physician Masterfile Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>General Practice, Family Practice</td>
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<tr>
<td>Internal Medicine</td>
<td>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</td>
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<tr>
<td>Pediatrics</td>
<td>Pediatrics, Pediatric Allergy, Pediatric Cardiology</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>Obstetrics and Gynecology</td>
</tr>
<tr>
<td>Radiology</td>
<td>Diagnostic Radiology, Radiology, Radiation Oncology</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Psychiatry, Child Psychiatry</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>Anesthesiology</td>
</tr>
<tr>
<td>Pathology</td>
<td>Forensic Pathology, Pathology</td>
</tr>
<tr>
<td>Other Specialty</td>
<td>Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified</td>
</tr>
</tbody>
</table>
At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a detailed explanation of its judicial function. This undertaking was motivated in part by the considerable attention professionalism has received in many areas of medicine, including the concept of professional self-regulation.

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

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

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

<table>
<thead>
<tr>
<th>Physicians Reviewed</th>
<th>Determinations of no probable cause</th>
<th>Determinations following a plenary hearing</th>
<th>Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing</th>
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<tr>
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### FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS

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<tr>
<th>Physicians Reviewed</th>
<th>No sanction or other type of action</th>
<th>Monitoring</th>
<th>Probation</th>
<th>Revocation</th>
<th>Suspension</th>
<th>Denied</th>
<th>Suspension lifted</th>
<th>Censure</th>
<th>Reprimand</th>
<th>Admonish</th>
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### PROBATION/MONITORING STATUS

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

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.\(^1\) Over the same time period (1998-2019),
the percentage of all U.S. workers in unions fell from 13.9 percent to 10.3 percent;\(^2\) the proportion
of physicians, residents and fellows in unions is increasing against the national trend of all workers.

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.\(^3\)

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

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

- Roughly 400 primary and urgent-care providers across more than 50 clinics operated by
  the Allina Health System in Minnesota and Wisconsin voted to unionize in October 2023,
  appearing at the time to be the largest group of unionized private-sector physicians in the
  United States. More than 150 nurse practitioners and physician assistants at the clinics
  were also eligible to vote and became members of the union.\(^5\) Further appeals by Allina
  were unsuccessful.\(^6\)
• Physicians at six Legacy Health hospitals in Oregon and Washington voted to unionize; the vote was certified by the National Labor Relations Board November 17, 2023. The hospitalists’ decision to unionize had the stated goals of improving local health care and giving frontline physicians a voice in the decisions that impact their patients’ care, communities’ health and hospital working conditions. Approximately 200 hospitalists employed by Legacy Health joined the approximately 700 Oregon Nurses Association nurses and mental and behavioral health professionals already employed by the system, making it one of the largest hospitalist union groups in the country.  

• In January 2024, residents and fellows at Northwestern University's McGaw Medical Center voted to unionize, citing concerns with a lack of information around pay increases and benefits from the health system. More than 1,300 residents and fellows were set to join the Committee of Interns and Residents/Service Employees International Union after nearly 800 voted in favor of the move. The Committee of Interns and Residents (CIR) is the largest housestaff union in the United States, representing over 32,000 resident physicians and fellows as of March 2024.

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

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

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

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

SCENARIO DEVELOPMENT

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

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

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

- Overall strength of the U.S. economy
- Patient perception of quality of care
- Consequences/ethics of work stoppages
- Working conditions

These driving forces were subsequently combined into two matrices, from which were created eight distinct scenario spaces (S1-S8):
The Council considered what the implications of each scenario space would be for physicians and patient care, and, subsequently, what role the AMA could play in supporting physicians in each scenario. 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.

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

### Scenario Spaces

<table>
<thead>
<tr>
<th>Economic Strength</th>
<th>Consequences/Ethics of Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong</td>
<td>Acceptable</td>
</tr>
<tr>
<td>Negative</td>
<td>Positive</td>
</tr>
<tr>
<td>S1</td>
<td>S5</td>
</tr>
<tr>
<td>S2</td>
<td>S6</td>
</tr>
<tr>
<td>S3</td>
<td>S7</td>
</tr>
<tr>
<td>S4</td>
<td>Unacceptable</td>
</tr>
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#### Scenario 1 – Strong Economy & Negative Patient Perception of Quality of Care

In a scenario in which the economy is strong, but patients have a negative perception of quality of care, the Council identified several challenges and opportunities. In terms of opportunities, the Council noted that in times of economic prosperity, the position of unions, and the overall position from which physicians could collectively bargain would be enhanced. Most obviously, employers in such a scenario would have opportunities to make payment concessions. This could be of particular benefit to residents and fellows, to whom payment and quality of life relative to working hours is an ongoing concern. More directly related to the negative perception of quality of care, physicians in such a scenario would likely be able to advocate and negotiate toward changes in health systems and care delivery that would enhance patient satisfaction. For instance, physicians negotiations could work toward allowing physicians to spend more time with individual patients, which can lead to increased patient satisfaction. Furthermore, improvements in how a clinic is run, e.g., adequate staffing, setting and managing expectations, facilitating streamlined and personalized communication between physicians, staff and patients might all be negotiated for in a strong economic environment, which could have the twofold benefit of improving patient satisfaction and improving working conditions in the future. CLRPD identified study, communication, and messaging as primary roles of the AMA in such a scenario. It would be essential to understand the drivers of the poor perception of quality of care and communicate those to physician groups as bases for negotiations. Additionally, identifying and sharing practices that lead to improved patient satisfaction could help unions and other physicians engaged in
negotiations to self-assess and pinpoint potential points of action that have been proven to improve
the patient experience. On a high level, the AMA’s most valuable roles in such an environment
would be to help physicians understand the patient experience, identify solutions that have been
shown to improve those experiences, and communicate those solutions to aid in collective
bargaining during a time when physicians would be expected to be in a stronger position to make
appreciable gains through negotiation.

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

Scenario 3 – Weak Economy & Negative Perception of Patient Care
The converse of Scenario 2, this scenario imagined an environment in which the economy is weak,
and patients have a poor perception of the quality of care they receive. In such a scenario, it was
noted that everyone would be struggling, i.e., patients, physicians, and employers. This could be
described as a “stop the bleeding” scenario in which negotiations would focus on preventing the
weakening of the position of physicians. Among the focal points the Council identified as
particularly significant in such a scenario were scope of practice and burnout. Health systems in
weak financial situations will look for opportunities to reduce costs, which may include increasing
the use of non-physician providers. It would be essential in such a scenario for physician unions
and physician negotiators to push back against scope creep through collective bargaining. In health
systems where patient care was already being delivered by mid-level providers, poorly perceived
quality of care could act as an argument against scope creep. Conversely, health systems in which
patient care was predominantly being delivered by physicians may attempt to leverage patient
dissatisfaction to push for increased utilization of mid-level providers. Physicians would need data
demonstrating the true effects of scope creep as it relates to both cost and quality. Other tendencies
in such an environment would likely be to push physicians, residents and fellows into working
longer hours, shorter and higher quantities of patient visits, and cost cutting measures, all factors
likely to lead to even further reduced quality of care, poorer quality of life and worse educational
environments for physicians in training, and increased burnout. The AMA’s work on burnout could
Scenario 4 – Weak Economy & Positive Patient Perception of Quality of Care
The Council noted that in this scenario, most of the issues related to a poor economy would still be relevant, as employers in a weak economy would still likely attempt to cut costs and get more for less. In theory, physicians in this scenario should be better positioned to negotiate against cost-cutting measures such as scope creep, as high patient perception of quality of care should be a focus of collective bargaining and a strong argument against such measures. However, several complicating scenarios were noted, including the possibility that in such an environment, employers may be more willing to take risks in care delivery, viewing the positive patient perception of quality as a backstop against possible declines. Additionally, the Council noted the distinction between patient perception of quality and quality care itself, and that some patients receiving direct care from mid-level providers may have a higher perception of the quality of care they receive (for instance, if mid-level providers spend more time with their patients than physicians can). It was also noted that by replacing one physician with two mid-level providers, health systems could charge more, thereby increasing revenue at the expense of both physicians and quality of care. Still, in an environment in which patient perception of quality is positive, the AMA could examine the causes of that positive perception, identify best practices to reduce costs while preserving quality of care, and communicate those best practices to health systems and physicians.

Scenario 5 – Negative Working Conditions & An Acceptable View of Work Stoppages
A complicating scenario related to physician unionization is the idea of work stoppages and the potential impacts of work stoppages on the health of patients. Section 1.2.10 in the Code of Medical Ethics states that physicians who participate in advocacy should “[a]void 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.” As unionization becomes more prevalent among physicians, unions will explore all possible tactics to increase leverage during collective bargaining. In January 2024, thousands of junior physicians in the United Kingdom (UK) engaged in a six-day strike over low wages leading to the postponement of more than 110,000 appointments. Senior doctors and other medical professionals were available to cover emergency services, critical care, and maternity services. This represented the longest strike in the history of the UK’s National Health Service (NHS). The NHS national medical director said it would take hospitals “weeks and months” to recover from the stoppage. Despite the obvious impacts physician work stoppages have on health care delivery, it is impossible to ignore the possibility that they may become a reality in the United States in an environment with a more highly unionized physician workforce. There are obvious parallels to be drawn between junior physicians in the United Kingdom and residents and fellows in the United States, who earn significantly less than their more senior colleagues, while working potentially more hours per week.

Scenario 5 imagines a situation in which physician working conditions are poor and the consequences of work stoppages are viewed as an acceptable tactic in collective bargaining. While what is “acceptable” will always vary between groups, individuals, organizations, etc., this scenario is one where the opportunity for work stoppage or the threat of work stoppage and other forms of collective action is most realistic. The Council noted that in such a scenario, it would be essential for the AMA to provide a backstop of support demonstrating the moral and ethical duty of physicians to act in the best interest of patient care and communicate that work stoppages are not and should not be about money, but about physicians doing what they can to fulfill their duty to
their oath and to their patients. Members also noted that work stoppages can take a variety of
forms, such as—like in the case of the NHS strike—predetermined and preannounced periods of
unavailability by physicians in an effort to highlight system inadequacies (rather than, for instance,
a strike of indeterminable duration) and that this types of collective action could more easily be
viewed as action toward improving patient care and not harming it. On a high level, this scenario
made apparent the likelihood of a future in which physician work stoppages of some form, and the
downstream consequences of those stoppages, would become a reality, and the AMA’s most
effective means of supporting physicians in such an environment will need to be considered,
particularly as it relates to potential conflict with AMA policy and the Code of Medical Ethics. In
response to policy adopted at the 2023 Annual Meeting of the House of Delegates (H-405.946,
“Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization)
the Council on Ethical and Judicial Affairs (CEJA) is developing a report for the 2024 Interim
Meeting “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.” Current AMA policy on unions and collective bargaining has
been appended to this memo.

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

Scenario 7 – Negative Working Conditions & An Unacceptable View of Work Stoppages
In Scenario 7 it becomes essential to identify solutions and collective bargaining strategies to push
toward improved conditions without the threat of work stoppage. If the public and/or physicians
themselves determine that any level of disruption to care delivery cannot occur, unions will
necessarily find themselves in a weakened position for negotiation. The AMA could aid physicians
in such a scenario by identifying, or proliferating already identified, successes that have occurred
without the need for work stoppages. The Council also noted that in a scenario in which working
conditions are deteriorating, but work stoppages are not an option, physicians may simply choose
to quit, leading to a worsening physician shortage and poorer access to quality care. The Council
noted that this scenario space is not unlike what physicians encountered during the worst of the
COVID-19 pandemic, during which working conditions were as bad as they could have been, but
no physician group would have been willing to threaten a strike even if they were already in a
union or looking to join one. That situation led to early retirements and physicians considering
alternative career paths, along with rises in physician mental health issues and suicides. Non-
compete clauses also present a significant challenge in such an environment, as physicians dealing
with declining working conditions who have signed such clauses cannot simply change systems but
must either relocate or remain and suffer. Providing support and resources to physicians in
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
to work toward these goals will change along with environmental factors and changing models of care delivery and organizational structures. The Council will continue to monitor this evolving area.

REFERENCES

4. Ibid.
12. Ibid.
13. Two simple ways to improve patient satisfaction with visit length. AAFP. [https://www.aafp.org/pubs/fpm/blogs/inpractice/entry/visit_length.html#:~:text=Researchers%20found%20that%20satisfaction%20with%20visit%20length%20was%20higher%20and%20better%20perceived%20among%20patients%20who%20had%20an%20extended%20visit](https://www.aafp.org/pubs/fpm/blogs/inpractice/entry/visit_length.html#:~:text=Researchers%20found%20that%20satisfaction%20with%20visit%20length%20was%20higher%20and%20better%20perceived%20among%20patients%20who%20had%20an%20extended%20visit). Accessed February 9, 2024.
# Appendix 1 – Committee of Interns and Residents Unionized Hospitals

## CALIFORNIA

<table>
<thead>
<tr>
<th>Hospital / Medical Center</th>
<th>City</th>
<th>State</th>
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## FLORIDA

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## NEW MEXICO

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<td>Bronx Lebanon Hospital Center</td>
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<thead>
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<td>St. Elizabeths Hospital</td>
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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.
Subject: Health System Consolidation

Presented by: Sheila Rege, MD, Chair

At the 2023 Annual Meeting, the House of Delegates adopted Policy D-160.907, Health System Consolidation, which directed the American Medical Association (AMA) to: 1) assess and report annually on nationwide health system and hospital consolidation, as well as payer consolidation, to assist policymakers and the federal government; 2) that the annual report on nationwide hospital consolidation 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; and d) analyses of how health care costs and price have changed in affected markets after large consolidation transaction has taken place; 3) that the AMA report the initial findings of this study to the House of Delegates by the 2024 Annual Meeting; and 4) that the AMA report the findings of this study to its members and stakeholders, including policymakers and legislators, to inform future health care policy.

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

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

BACKGROUND

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

\[25^2 + 25^2 + 25^2 + 25^2 = 2,500\]
If the number of firms in a market increased, the HHI would generally decrease, and vice versa.  

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

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

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

AMA POLICY  

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

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

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

CMS 3-I-22, Health System Consolidation, was an informational report and the first in a series the Council has on this and related topics. CMS 3-I-22 shared background information on vertical and horizontal mergers and acquisitions and highlighted notable transactions from 2020. The Council
will continue its work on this issue and provide additional reports for the consideration of the
House of Delegates when appropriate.

Policy D-160.907, established by the adoption of Resolution 727-A-23 as amended, states that the
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; model this report
on nationwide hospital consolidation after the “Competition in Health Insurance” study in its
comprehensiveness to include for example, data and analyses such 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; a list of all mergers and acquisition transactions valued above a set
threshold amount resulting in hospital and/or health system consolidation; analyses of how each
transaction has changed or is expected to change the level of competition in the affected service
and geographic markets; analyses of how health care costs and prices have changed in affected
markets after a large consolidation transaction has taken place.

Policy H-160.884 states that the AMA opposes not-for-profit firm immunity from FTC competition
policy enforcement in the health care sector, 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, and supports health care-specific
advocacy efforts that will strengthen antitrust enforcement in the health care sector through
multiple mechanisms.

Policy H-215.960 states that the AMA: 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. The AMA
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.

Policy H-215.969 states that 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 that the 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.

Policy D-215.984 states that the AMA will 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 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.

Policy D-225.995 states that the AMA will continue to monitor and report on current numbers of
mergers and break-ups of mergers of hospitals in this country. Policy D-383.980 states that the
AMA will 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 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.

DISCUSSION

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

REFERENCES

American Medical Association. 2024.
### Appendix A1
Hospital Market Shares and System Membership, 2013-2021

<table>
<thead>
<tr>
<th>Variable</th>
<th>2013</th>
<th>2017</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Markets where at least 1 hospital’s share &gt;=30%</td>
<td>95%</td>
<td>96%</td>
<td>97%</td>
</tr>
<tr>
<td>% of Markets where 1 hospital’s share &gt;=50%</td>
<td>70%</td>
<td>72%</td>
<td>77%</td>
</tr>
<tr>
<td>% of Markets where 1 hospital’s share &gt;=70%</td>
<td>37%</td>
<td>40%</td>
<td>43%</td>
</tr>
<tr>
<td>% of Hospitals that are members of systems</td>
<td>70%</td>
<td>76%</td>
<td>78%</td>
</tr>
<tr>
<td>Number of hospitals</td>
<td>1946</td>
<td>2021</td>
<td>2002</td>
</tr>
<tr>
<td>Number of systems</td>
<td>276</td>
<td>273</td>
<td>268</td>
</tr>
<tr>
<td>Number of markets</td>
<td>363</td>
<td>387</td>
<td>389</td>
</tr>
</tbody>
</table>

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.
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

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

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.

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.

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.

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.

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

BACKGROUNDS

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

ITEMS FOR DISCUSSION

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

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

Glossary

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

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

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

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

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ETF 2 Proposed Language  
*(Proposed changes to current policy or items from ETF 2 I-23 report shown in red)*

**Proposed changes to current policy:**

<table>
<thead>
<tr>
<th>Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, AMA, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Only an announced candidate in a currently contested election may discuss their candidacy on an individual basis in private conversations from announcement of candidacy until the active campaigning period begins. Prior to the active campaigning period, no other individual may discuss the candidacy, including members of campaign teams, delegations or caucuses, and “friends.” This rule does not prohibit any candidate from discussions for the purpose of forming a campaign team nor from a campaign team discussing a candidate or campaign strategy. This rule also does not prohibit persons not associated with a campaign from discussing candidates in private conversations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>ETF 2 Proposed Language</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Proposed changes to current policy:</strong></td>
</tr>
</tbody>
</table>
| ***Printed and digital campaign materials may not be distributed to members of the House other than by the HOD office candidate email and on the Candidate Web Pages, by postal mail or its equivalent.*** The AMA Office of House of Delegates Affairs will no longer furnish a file containing the names and mailing addresses of members of the AMA-HOD. Printed campaign materials will not be included in the “Not for Official Business” bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials. | |}

| Proposed changes to current policy: | 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. |
| Active campaigning via mass outreach to delegates by candidates or on behalf of a candidate by any method is prohibited. A reduction in the volume of campaign-related telephone calls and personal electronic communication from candidates and on behalf of candidates is encouraged. **No part of this rule shall be interpreted to limit communication among members of a campaign team.** The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages. | |
ETF 2 Proposed Language  
*(Proposed changes to current policy or items from ETF 2 I-23 report shown in red)*

<table>
<thead>
<tr>
<th>Proposed changes to current policy:</th>
<th>Rationale</th>
</tr>
</thead>
</table>

Groups conducting interviews with announced candidates for a given office must offer an interview to all individuals that have officially announced their candidacy at the time the group’s interview schedule is finalize announced candidates at the time the group’s interview schedule is finalized.

a. A group may meet with an announced candidate who is a member of their group during the active campaign window without interviewing other candidates for the same office.

b. Interviewing groups may, but are not required to, interview late announcing candidates persons who become announced candidates during the active campaign window. Should an interview be offered to a late candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.

c. Any appearance by a candidate before an organized meeting of a caucus or delegation, other than their own, will be considered an interview and fall under the rules for interviews. Any appearance campaign-related presentation to an assembly by an announced candidate, with or without being followed by a discussion, question and answer session, or a vote of the assembly regarding the candidate, is an interview and subject to the rules on in-person interviews. No portion of this rule shall be interpreted to mean that a candidate acting in a formal capacity would be unable to present or discuss matters pertaining to that formal capacity with any group.

*New language referred at I-23 with proposed changes.*

Candidates may not produce a personal campaign-related website or other digital campaign-related content or direct to personal or professional websites that contain campaign materials other than the AMA Candidates’ Page.

*The language in this section provides clarity that explicitly defines that the only authorized campaign or digitally related websites, pages, or other campaign related materials for candidates is a web page provided by the AMA. This allows all candidates to be on equal footing during the election process.*
ETF 2 Proposed Language  
*(Proposed changes to current policy or items from ETF 2 I-23 report shown in red)*  

<table>
<thead>
<tr>
<th>Proposed changes to current policy:</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active campaigning for <strong>AMA elective office</strong> an <strong>elected position</strong> may not begin until the <strong>active campaign window</strong> opens as announced by the <strong>Speaker Board of Trustees</strong>, after its April meeting, announces the candidates for council seats. <strong>Active campaigning</strong> includes mass outreach activities directed to all or a significant portion of the members of the <strong>House of Delegates</strong> and communicated by or on behalf of the <strong>candidate</strong>. If in the judgment of the <strong>Speaker of the House of Delegates</strong> circumstances warrant an earlier date by which campaigns may formally begin, the <strong>Speaker</strong> shall communicate the earlier date to all known candidates.</td>
<td>The <strong>Election Task Force</strong> heard questions concerning timelines for active campaigning in the course of an Election cycle. <strong>Active Campaigning</strong> is defined as outreach by candidates or their surrogate(s), including but not limited to members of their campaign team, to members of the <strong>House of Delegates</strong>, with the goal of being elected by the <strong>AMA House of Delegates</strong>. Active Campaigning activities typically may not occur until after the April meeting of the <strong>Board of Trustees</strong>, when candidates for Council Seats are announced. The specific dates of the <strong>Active Campaigning Window</strong> will be announced by the <strong>Speaker</strong>. The <strong>Active Campaigning Window</strong> is defined as the period of time after the <strong>Speaker's notice</strong> of the opening of active campaigning until the <strong>Election Session</strong> during the <strong>House of Delegates meeting</strong> at which elections are being held.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New language referred at I-23 with proposed changes.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Candidates and their identified members of campaign teams</strong> will be provided a copy of the current election rules and will be required to attest to abiding by them. <strong>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.</strong></td>
<td><strong>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.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New item referred at I-23 (shown below) with proposed new language:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>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.</strong></td>
<td><strong>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.</strong></td>
</tr>
</tbody>
</table>

[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.**]
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

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

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

The Speakers, in concert with the Council on Constitution and Bylaws, have reviewed the AIPSC (2nd ed.) and compared the rules therein to usual practice in the House of Delegates and in the House of Delegates Reference Manual: Procedures, Policies and Practices. The HOD Reference Manual delineates the HOD’s Standing Rules, and is presented in a Rules Report that is adopted by the HOD at each meeting by majority vote, with the Rules Report stating that the HOD Reference Manual shall be the official method of procedure in handling and conducting the business of the AMA House of Delegates. [The AIPSC (2nd ed.) is available for purchase on Amazon in Kindle and print versions.]
AIPSC (2nd ed.) identified the following as among the substantive changes:

- Replacing the concept of restricted debate with a requirement that debate be germane to the motion at hand. (No change required as this is current AMA practice. Note, this would also be inclusive of motions to refer, reconsider and postpone debate);

- Making Close Debate and Vote Immediately amendable as to the motions to which it applies. (Rather than making the motion amendable, your Speakers have elected to continue our current AMA practice in which the maker of the motion may specify to which items they wish to apply the motion with the caveat that both sides must have been heard on each item);

- Removing the debatability of motions that limit debate. (The motions Object to Consideration* and Limit or Extend Debate will no longer be debatable);

*The motion Object to Consideration requires a ¾ vote and is unique to the AMA. This was adopted by the HOD at A-16. However, as it limits debate, it will no longer be debatable.

- Removing the concept of a substitute amendment. (No change required as current AMA practice treats substitute amendments as motions to adopt in lieu of);

- Establishing that after debate has been closed, Factual Inquiries are not permitted, although a Parliamentary Inquiry may be. (This rule will be implemented);

- Clarifying the methodology and motions used to create a continued meeting. (No change required as AMA items of business are not held over for future meeting);

- Some Main Motions have been retitled as Specific-Purpose Main Motions. (Retitled appropriately on the HOD Reference Manual’s Parliamentary Quick Tips Chart, which is appended to this report);

- Special Orders were renamed Scheduled Orders. (Not applicable);

- Standing Rules are now designated as “Standing Rules of Order” or “Temporary Rules. (The House of Delegates Reference Manual constitutes our Standing Rules of Order. These are highlighted in the Rules Report along with any Temporary Rules for that meeting.);

- Clarifying rules related to the Credentials Committees, whereby the initial Credentials Committee lists the names of members entitled to vote. (Not applicable as the current AMA practice is to identify credentialed delegates in “The Official Call” with the Committee on Rules and Credentials reporting each day only the number of credentialed delegates in attendance and whether a quorum has been met. The HOD Proceedings reflect the final listing of members of the HOD.)

The nuances of these changes are addressed in the HOD Reference Manual and incorporated into the “Parliamentary Quick Tips” chart that appears as an appendix in the HOD Reference Manual and which is attached to this report also. The Rules Report, to be presented at A-24, will once again ask the HOD to adopt the HOD Reference Manual as the official method of procedure in handling and conducting the business of the AMA House of Delegates.
There also are several other changes that require additional action: AIPSC (2nd ed.) establishes electronic notice (of a meeting) as the default notification and there are several bylaw provisions (2.12.2, 2.12.3.1, 5.2.4, 5.2.4.1 and 12.3) that specify notification by mail or in writing. The Council has submitted amended bylaw language via CCB Report 4-A-24, AMA Bylaw Amendments Pursuant to AIPSC (2nd ed.).

RELEVANT AMA BYLAWS

2.12.2 Special Meetings of the House of Delegates. Special Meetings of the House of Delegates shall be called by the Speaker on written or electronic request by one third of the members of the House of Delegates, or on request of a majority of the Board of Trustees. When a special meeting is called, the Executive Vice President of the AMA shall mail a notice to the last known address of each member of the House of Delegates at least 20 days before the special meeting is to be held. The notice shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the meeting is called.

2.12.3.1 Invitation from Constituent Association. A constituent association desiring a meeting within its borders shall submit an invitation in writing, together with significant data, to the Board of Trustees. The dates and the city selected may be changed by action of the Board of Trustees at any time, but not later than 60 days prior to the dates selected for that meeting.

5.2.4 Notice of Meeting. Notice is given if delivered in person, by telephone, mail, or any means of electronic communication approved by the Board of Trustees. Notice shall be deemed to be received upon delivery to the Trustee’s contact information then appearing on the records of the AMA.

5.2.4.1 Waiver of Notice. Notice of any meeting need not be given if waived in writing before, during or after such meeting. Attendance at any meeting shall constitute a waiver of notice of such meeting, except where such attendance is for the express purpose of objecting to the transacting of any business because of a question as to the legality of the calling or convening of the meeting.

12.3 Articles of Incorporation. The Articles of Incorporation of the AMA may be amended at any regular or special meeting of the House of Delegates by the approval of two-thirds of the voting members of the House of Delegates registered at the meeting, provided that the Board of Trustees shall have approved the amendment and submitted it in writing to each member of the House of Delegates at least 5 days, but not more than 60 days, prior to the meeting of the House of Delegates at which the amendment is to be considered.
Appendix B: Parliamentary Quick Tips
Adapted from AIPSC (2nd ed.) for AMA House of Delegates

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.

<table>
<thead>
<tr>
<th>Type of Motion</th>
<th>Privileged</th>
<th>Subsidiary</th>
<th>Incidental</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>May Interrupt Speaker?</td>
<td>Requires a Second?</td>
<td>Is motion debatable?</td>
</tr>
<tr>
<td>Adjourn the meeting</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Recess the meeting</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Question of privilege¹</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Object to consideration²</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Table²</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Close debate and vote immediately</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Limit or extend debate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Postpone to a certain time</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Referred for decision³</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Referred for report</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Amend</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>a. The main motion (introduce)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>b. Specific-purpose main motions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adopt in lieu of</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Reconsider</td>
<td>Yes*</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

| Motions | Yes | Yes | Yes | No | Majority |
| Appeal a decision by the Speaker | Yes | Yes | Yes | No | Majority |
| Suspend the Rules | No | Yes | No | No | Two-thirds |

| Requests | Yes | No | No | No | None |
| Point of order⁴ | Yes | No | No | No | None |
| Inquiries⁵ | Yes | No | No | No | None |
| Division of question | No | No | No | No | None |
| Division of House | Yes | No | No | No | None |

Definitions:

¹ Question of privilege: Raising a question of privilege allows a single member to request immediate action affecting safety, health, security, comfort, or integrity, including the rights and privileges of a member or members or of the HOD generally.

² Object to consideration: Per HOD action at A-16, this motion is unique to the AMA and is used when a delegate objects to HOD consideration of an item. It cannot interrupt a speaker, requires a second, cannot be amended and takes precedence over all subsidiary motions and cannot be renewed. It requires a ¾ vote. However, per AIPSC (2nd ed.) as it limits debate, it will no longer be debatable.

³ Refer for decision: Per HOD action at A-16, this motion is used when a delegate wants the Board to determine the appropriate course of action and proceed, and report back on its decision and the action taken. It is one step higher in precedence than the Motion to Refer.

⁴ Point of order: A point of order calls to the attention of the Speaker and the HOD an alleged violation of the rules, an omission, a mistake, or an error in procedure and secures a ruling on the question raised.

⁵ Inquiries: An inquiry allows a member (1) to ask the Speaker a question relating to procedure in connection with the pending motion or with a motion the delegate may wish to bring immediately before the HOD (Parliamentary Inquiry); or (2) to request substantive information or facts about the pending motion or for information on the meaning or effect of the pending question from the Speaker or a delegate (Factual Inquiry)

* 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.

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