REPORTS OF THE BOARD OF TRUSTEES

The following reports were presented by Michael Suk, MD, JD, MPH, MBA, Chair:

1. ANNUAL REPORT

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: FILED

The Consolidated Financial Statements for the years ended December 31, 2024 and 2023 and the Independent Auditor's report have been included in the 2024 Annual Report, that is included in the Handbook mailing to members of the House of Delegates.

2. NEW SPECIALTY ORGANIZATIONS REPRESENTATION IN THE HOUSE OF DELEGATES

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

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

The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the applications of the American Academy of Emergency Medicine and American Society for Laser Medicine and Surgery, Inc. for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

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

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

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

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

Review of the materials and discussion during the SSS meeting at the November 2024 Interim Meeting indicated that the American Academy of Emergency Medicine and American Society for Laser Medicine and Surgery, Inc. meet the criteria for representation in the HOD.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the American Academy of Emergency Medicine and American Society for Laser Medicine and Surgery, Inc. be granted representation in the AMA House of Delegates and that the remainder of the report be filed. (Directive to Take Action)

Fiscal Note: Less than $500

APPENDIX

Exhibit A

GUIDELINES FOR REPRESENTATION IN & ADMISSION TO THE HOUSE OF DELEGATES:

National Medical Specialty Societies

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

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

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

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

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

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

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

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

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

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

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

RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS

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

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

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

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

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

Exhibit B - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
American Academy of Emergency Medicine*	1,727 of 6,270 (28%)
American Society for Laser Medicine and Surgery, Inc.	323 of 1,156 (28%)

* *Represented in the House of Delegates at the 1990 Annual Meeting*

3. 2024 GRANTS AND DONATIONS

Informational report; no reference committee hearing.

HOD ACTION: FILED

This informational financial report details all grants or donations received by the American Medical Association during 2024.

American Medical Association
Grants & Donations Received by the AMA
For the Year Ended December 31, 2024
Amounts in thousands

Funding Institution	Project	Amount Received
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Building Healthcare Provider Capacity to Screen, Test, and Refer Disparate Populations with Prediabetes	$ 50
Centers for Disease Control and Prevention	Engaging Physicians to Strengthen the Public Health System and Improve the Nation's Public Health	488
Centers for Disease Control and Prevention	Improving Health Outcomes through Partnerships with Physicians to Prevent and Control Emerging and Re-Emerging Infectious Disease Threats	23
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Improving Minority Physician Capacity to Address COVID-19 Disparities	112
Centers for Disease Control and Prevention	National Healthcare Workforce Infection Prevention and Control Training Initiative Healthcare Facilities	81
Centers for Disease Control and Prevention	Physicians and Medical Students: Prevention Rx: Engaging Physicians to Enhance Public Health	20

American Medical Association
Grants & Donations Received by the AMA
For the Year Ended December 31, 2024
Amounts in thousands

Funding Institution	Project	Amount Received
Centers for Disease Control and Prevention	Protecting and Improving Health Globally: Building and Strengthening Public Health Impact, Systems, Capacity and Security	1,774
Substance Abuse and Mental Health Services Administration (subcontracted to AMA through American Academy of Addiction Psychiatry)	Providers Clinical Support System Medications for Opioid Use Disorders	11
Government Funding		
American Chemical Society	International Congress On Peer Review and Scientific Publication	**2,559**
American College of Physicians, Inc.	International Congress On Peer Review and Scientific Publication	20
American Medical Association Foundation	Health Equity Acceleration Fund	
American Medical Association Foundation (supported by Robert Wood Johnson Foundation funding)	The Truth, Reconciliation, Healing, and Transformation Project	10
		341
Nonprofit Contributors	International Congress On Peer Review and Scientific Publication	
John Wiley & Sons, Inc.	International Medical Graduates Section Reception	520
Contributors less than $5,000		**891**
Other Contributors		
Total Grants and Donations		30
		5
		35
		$ 3,485

4. AMA 2025 DUES

Reference committee hearing: see report of Reference Committee F.

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

Our American Medical Association (AMA) last raised its dues in 1994. The AMA continues to invest in improving the value of membership. As our AMA's membership benefits portfolio is modified and enhanced, management will continuously evaluate dues pricing to ensure optimization of the membership value proposition.

RECOMMENDATION

2026 Membership Year

The Board of Trustees recommends no change to the dues levels for 2026, that the following be adopted and that the remainder of this report be filed:

Regular Members	$ 420
Physicians in Their Fourth Year of Practice	$ 315
Physicians in Their Third year of Practice	$ 210
Physicians in Their Second Year of Practice	$ 105
Physicians in Their First Year of Practice	$ 60
Physicians in Military Service	$ 280
Semi-Retired Physicians	$ 210
Fully Retired Physicians	$ 84
Physicians in Residency/Fellow Training	$ 45
Medical Students	$ 20

(Directive to Take Action)

Fiscal Note: No significant fiscal impact.

5. UPDATE ON CORPORATE RELATIONSHIPS

Informational report; no reference committee hearing.

HOD ACTION: FILED

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2024. 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 Meetings. AMA management is responsible for reviewing AMA projects to ensure they fit within these guidelines.

YEAR 2024 RESULTS

In 2024, 102 activities were considered and approved through the Corporate Review process. Of the 102 activities recommended for approval, 52 were conferences or events, 11 were educational content or grants, 33 were collaborations or affiliations, four were member programs and two were business arrangements/licensing programs. 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 2024

CONFERENCES/EVENTS

Project Number	Project Description	Corporations	Approval Date
48882	**Bryce Harlow Foundation 42nd Annual Awards Dinner -** Sponsorship with AMA name and logo.	Bryce Harlow Foundation	01/17/24
48561	**Anarcha, Lucy, Betsey Annual Conference** – Sponsorships with AMA name and logo.	The More Up Campus Faith Crusade Montgomery Rescue Mission	01/19/24
48398	**National Rx & Illicit Drug Summit -** Repeat sponsorship with AMA name and logo.	Healthcare Made Practical (HMP) Global	01/22/24
48956	**Becker's Collaborations -** CEO & CFO Roundtables, Annual Hospital Review, White paper and Webinar with AMA name and logo.	Becker's Hospital Review ASC Communications	01/24/24
49031	**National Independent Laboratory Association Annual Meeting -** Repeat sponsorship with AMA name and logo.	American Association of Bioanalysts AIMA Business and Medical Support LLC BacterioScan Lighthouse Lab Services BioPathogenix Credence Global Solutions	01/29/24

49012	**NAMSS 48th Annual Educational Virtual Conference and Exhibition** - Repeat sponsorship with AMA name and logo.	National Association of Medical Staff Services ABMS Solutions Medallion Qgenda HealthStream MD-Staff National Committee for Quality Assurance RLDatix Symplr Axuall Medicred PreCheck Santech Acorn Credentialing AOA Profiles Federation of State Medical Boards The Hardenbergh Group Verifiable Credentialing	01/31/24
49056	**March of Dimes Gourmet Gala -** Repeat sponsorship with AMA name and logo.	March of Dimes Blue Cross Blue Shield Association Pampers Comcast WalMart Abbott AdvaMed	02/01/24
48932	**South by Southwest Conference** - Sponsorship with AMA name and logo.	South by Southwest Johnson & Johnson	02/01/24
48908	**Machine Learning for Healthcare Conference** - Sponsorship with AMA name and logo.	Columbia University Johns Hopkins University Duke University Apple Microsoft	02/06/24
48795	**Ottawa Conference 2026** - Sponsorship of continuing medical education conference with AMA name and logo.	Association for Medical Education in Europe (AMEE)	02/06/24
48850	**ViVE Sponsorships** – Repeat sponsorships with AMA name and logo.	College of Healthcare Information Management Executives HLTH Inc.	02/06/24
48463	**AZARA User Conference** – Sponsorship with AMA name and logo.	Azara Healthcare	02/08/24
48958	**Art Institute of Chicago Exhibition –** Art exhibit featuring Journal of Ethics artwork and name and logo.	School of the Art Institute of Chicago	02/14/24
49206	**Chicago Cares Leadership Breakfast** – Repeat sponsorship with AMA name and logo.	Chicago Cares	02/19/24

49411	**International Association of Industrial Accident Boards and Commissions Convention -** Repeat sponsorship with AMA name and logo.	International Association of Industrial Accident Boards and Commissions National Council on Compensation Insurance Optum Aerie EDI Group The Black Car Fund Sedgwick Claims Management Service Concentra SFM Mutual Insurance Official Disability Guidelines by Milliman Care Guidelines Health Safety National Verisk	02/21/24
49259	**Medical Library Association Annual Meeting** – Sponsorship with JAMA Network name and logo.	Medical Library Association	02/23/24
49297	**ROCS Foundation Summit** – Repeat sponsorship with AMA name and logo.	ROCS Foundation John A. Hartford Foundation The Commonwealth Fund	02/26/24
49462	**Credentialing State Shows –** Repeat sponsorship with AMA name and logo.	Arizona Association of Medical Staff Services California Association of Medical Staff Services Illinois Association of Medical Staff Services Texas Society of Medical Services Specialists Florida Association of Medical Staff Services Massachusetts Association for Medical Staff Services New York State Association of Medical Staff Services Ohio Association Medical Staff Services Medical Staff Services Association of Pennsylvania Washington Association Medical Staff Services ABMS Solutions AMN Healthcare/Silversheet Barton Associates CIMRO Edge-U-Cate The Hardenbergh Group Hooper, Lundy & Bookman PC Lash & Goldberg MD Review MD Staff NAMSS PASS Polsinelli PreCheck Procopio PRS Credentialing Services Qgenda SkillSurvey Symplr VerityStream YS Credentialing	02/28/24

49453	**The Association of LGBTQ Journalists Annual Conference –** Repeat sponsorship with AMA name and logo.	The Association of LGBTQ Journalists Axios CBS News Fox News Hearst Corporation McClatchy Media Company DotDash Meredith Publishing Nexstar SAG-AFTRA Scripps Tegna The Athletic CNN TNT Sports	03/01/24
49458	**Asian American Journalists Association's Annual Convention** – Repeat sponsorship with AMA name and logo.	The Guardian Sinclair Broadcast Group IW Group Johnson & Johnson Pew Research Center	03/04/24
49483	**Healthcare Information Management Systems Society (HIMSS) Middle East Forum -** Sponsorship with AMA name and logo.	Healthcare Information Management Systems MWAN Events Gulf Cooperation Council eHealth ZIMAM Elsevier Dedalus	03/04/24
65938	**HIMSS Global Health Conference & Exhibition –** Sponsorship with AMA name and logo.	Healthcare Information Management Systems MWAN Events Gulf Cooperation Council eHealth ZIMAM Elsevier Dedalus	11/22/24
48811	**"Reckoning with Race and Racism in Academic Medicine" Conference –** Sponsorship with AMA name and logo.	Johns Hopkins School of Medicine American Association of Medical Colleges (AAMC) Molina Foundation Robert Wood Johnson Foundation National Institutes of Health	03/06/24
49096	**Bernard Lown Awards Dinner** – Sponsorship with AMA name and logo.	Lown Institute The Commonwealth Fund Robert Wood Johnson Foundation John A. Hartford Foundation Kaiser Permanente California Healthcare Foundation Gordon and Betty Moore Foundation Well-Being Trust Foundation Arnold. P. Gold Foundation	03/19/24
49253	**National Association of Black Journalists Convention** – Repeat sponsorship with AMA name and logo.	Bloomberg CBS Sports Climate Central Gannett Media Lumina National Association of Realtors	03/25/24

49214	**AMA International Medical Graduates Section Annual Meeting Desserts Reception –** Repeat sponsorship with AMA name and logo.	Association of Physicians of Pakistani Descent of North America Association of Haitian Physicians Abroad	03/29/24
50702	**Rock Health Summit –** Repeat sponsorship with AMA name and logo.	Rock Health Foundation California Health Care Foundation Google Tulsa Innovation Labs 1501 Health BioReference Laboratories Amazon Web Services Morgan Stanley Myovant Russell Reynolds	04/05/24
50519	**TruBridge National Client Conference** – Sponsorship with AMA name and logo.	TruBridge i2i Population Health Blockit SureScripts Wolters Kluwer	04/12/24
50589	**Southern Association of Workers' Compensation Administrators Convention and Luncheon** – Repeat sponsorship with AMA name and logo.	AKERA Claims Solutions American International Group Ametros CompTrust Mutual Insurance Company Concentra Enlyte FAIR Health Healthesystems Meridian Wealth Management National Council on Compensation Insurance Official Disability Guidelines by Milliman Care Guidelines Health Occupational Managed Care Alliance Optum Safety National Casualty Company Sedgwick Trean Corporation Verisk Workers' Compensation Institute	04/15/24
50575	**Essence Festival of Culture "Release the Pressure" Health Innovators Hub** – Repeat sponsorship with AMA and RTP name and logo.	Essence Festival New Voices Foundation	04/19/24
50586	**Greenway reENGAGE Client Summit** – Sponsorship with AMA name and logo.	Greenway Health Clearwave Phreesia Surescripts 3M Solventum HealthAsyst Relatient Instamed Vaytiv Updox	04/22/24

62721	**Project IMG (International Medical Graduate) Annual Conference** – Sponsorship with AMA name and logo.	Project IMG Palm Beach Atlantic University Brown University Intealth OET (Occupational English Test) mQ Mental Health Research Essen Healthcare UWorld Boards & Beyond American Medical Women's Association	06/06/24
62849	**Graphic Medicine Annual Conference** – Sponsorship with AMA Journal of Ethics name and logo.	Graphic Medicine International Collective Fáilte Ireland (National Tourism Authority) Meet in Ireland	06/21/24
62841	**American Society of Bioethics and Humanities Conference –** Sponsorship with AMA Journal of Ethics name and logo.	American Society of Bioethics and Humanities Hastings Center American Journal of Bioethics The Journal of Medicine and Philosophy Case Western Reserve University School of Medicine UCLA Health Ethics Center Sutter Health Belmont University Northwell Health Loyola University Bioethics Graduate Programs	06/26/24
62989	**Chief Medical Officer Exchange** – Repeat sponsorship with AMA name and logo.	Healthcare Compliance Professionals HealthLeaders Xtend Healthcare ShiftMed Solutions Vizient Inc. Optum R1 RCM Inc. Microsoft	07/05/24
63282	**Annual Convention and Scientific Assembly of the National Medical Association –** Repeat sponsorship with AMA name and logo.	National Medical Association Gilead Pfizer Hitachi Merck American College of Obstetricians and Gynecologists (ACOG) Glaxo Smith Kline Sutter Health ViiV Healthcare Regeneron Pharmaceuticals National Institutes of Health Centers for Disease Control and Prevention Morehouse School of Medicine Meharry Medical College Howard University College of Medicine University of Michigan University of Virginia The Ohio State University Harvard Medical School	07/10/24
63437	**Latino Medical Student Association National Conference** – Sponsorship with AMA Journal of Ethics name and logo.	Latino Medical Student Association	07/25/24

63241	**Facing Race: A National Conference** – Sponsorship with AMA, Rise to Health Coalition and Grand Rounds logos	Race Forward Accreditation Council for Graduate Medical Education RespectAbility National Center for Interprofessional Practice and Education Institute for Healthcare Improvement	07/26/24
63372	**Annual Princeton Conference** – Repeat sponsorship with AMA name and logo.	The Council on Health Care Economics and Policy at Brandeis University American Hospital Association Arnold Ventures Blue Cross Blue Shield of Massachusetts Foundation Blue Shield of California Foundation Booz Allen Hamilton California Health Benefits Review California Health Care Foundation Jewish Healthcare Foundation MAXIMUS Peterson Center on Healthcare The Health Industry Forum The John A. Hartford Foundation	07/29/24
64332	**Genetic Health Information Network Summit** - Repeat sponsorship with AMA name and logo.	Concert Genetics Illumina	08/07/24
64508	**Collaborative Family Healthcare Association Integrated Care Conference** – Repeat sponsorship with AMA name and logo.	Collaborative Family Healthcare Association The University of Texas Health Center of San Antonio American Psychological Association University of Nebraska Medical Center Munroe-Meyer Institute Area Health Education Centers EvolvedMD Health Federation of Philadelphia Merakey Mental Health Services National Register of Health Service Psychologists University of Houston Integrated Primary Care, Inc. The Foundation for Burnout Solutions Iris Telehealth	08/16/24
64665	**Southern College of Occupational and Environmental Medicine Conference** – Sponsorship with AMA name and logo.	Southern College of Occupational and Environmental Medicine Medlock Pfizer Psychemedics	09/03/24
65064	**MD-Staff Educational Conference -** Sponsorship with AMA name and logo.	MD-Staff PreCheck ABMS Solutions	09/20/24
65074	**Politico's Exchange Dinner** – Sponsorship with AMA name and logo.	Politico	09/26/24
65264	**HLTH Conference** - Repeat sponsorship with AMA name and logo.	HLTH Inc. HLTH Foundation	10/03/24

64748	**Association of American Medical Colleges Annual Meeting** – Repeat sponsorship with Journal of Ethics name and logo.	Association of American Medical Colleges	10/09/24
65537	**Women Business Leaders Annual Summit -** Repeat sponsorship with AMA name and logo.	Elevance Health Inc. Johnson & Johnson McKesson Corporation Tivity Health Amazon Web Services Epstein Becker & Green United Health Group Mintz Law Firm Newport Healthcare ProgenyHealth PYA Accounting Korn Ferry AArete Global Consulting Hello Heart Trustmark Medecision Morgan Health	10/18/24
65562	**College Art Association Annual Conference** – Sponsorship with AMA Journal of Ethics name and logo.	College Art Association JSTOR Digital Library Blick Art Materials University of California Press	10/29/24
66081	**Alliance for Continuing Education in the Health Professions Annual Conference** – Sponsorship with AMA EdHub name and logo.	Alliance for Continuing Education in the Health Professions Medlive/PlatformQ Conexiant PACE freeCME Medscape Partnership in International Management AcademicCME DKBmed Continuing Medical Education ReachMD Haymarket Media Talem Health NOVA Takeda Pharmaceuticals InfographEd CloudCME Med-IQ	11/18/24
66144	**AIDS Foundation of Chicago 40th Anniversary Gala –** Sponsorship with AMA name and logo.	BMO Harris Illinois Tool Works Kehoe Designs Morgan Stanley J&L Catering University of Illinois Health	11/25/24
66672	**Digital Health Innovation Ecosystems Forum** – Sponsorship with AMA name and logo.	MWAN Events OneSource Solutions International CHIME International HLTH Europe Scottish Developmental International MECOMED Invest Northern Ireland	12/27/24

66659	**Healthcare Burnout Symposium –** Sponsorship with AMA name and logo.	International Conference Development Events	01/02/25

EDUCATIONAL CONTENT OR GRANT

Project Number	Project Description	Corporations	Approval Date
50525	**OutCare Health Education** - AMA EdHub hosted content with AMA name and logo.	OutCare Health	04/24/24
49258	**Collaboration with National Association of County and City Health Officials** - AMA EdHub hosted content with AMA name and logo.	National Association of County and City Health Officials	03/12/24
49611	**Brain Health and Dementia Risk Reduction Collaboration** - AMA EdHub hosted continuing medical education with AMA name and logo.	Centers for Disease Control (CDC) Alzheimer's Association	03/19/24
62759	**Project Firstline Webinar - Building Blocks of Infection Prevention and Control -** AMA EdHub hosted continuing medical education with AMA name and logo.	CDC Project Firstline American Society of Nephrology	06/03/24
62924	**Measles: Stories from the Frontline** - AMA EdHub hosted content with AMA name and logo.	CDC Project Firstline Pediatric Pandemic Network American Academy of Pediatrics American Nurses Association	06/17/24
62981	**Language Equity Toolkit** – AMA EdHub hosted content with AMA name and logo.	Accreditation Council for Graduate Medical Education Association of American Medical Colleges National Council on Interpreting Health Care	07/05/24
64452	**American Health Information Management Association Workshop -** Training on clinical documentation coding with AMA name and logo.	American Health Information Management Association	08/14/24
64324	**MedCerts Collaboration** – MedCerts-hosted AMA content on improving BP measurements, with AMA name and logo.	MedCerts	08/16/24
64210	**Permanente Medical Group Collaboration** - AMA EdHub hosted content with AMA name and logo.	The Permanente Medical Group	08/29/24
64669	**Healthcare Webinar Series** - AMA sponsored segment on Medicare payment reform, with AMA name and logo.	WTOP Radio Federal News Network	09/03/24
65773	**Credentialing School Sponsorship** - Repeat sponsorship with AMA name and logo.	Edge-U-Cate Symplr The Hardenbergh Group	11/01/24

COLLABORATIONS/AFFILIATIONS

Project Number	Project Description	Corporations	Approval Date
48378	**Atlanta Hypertension Initiative –** Sponsorship of initiative improving hypertension in Atlanta area, with AMA name and logo.	Atlanta Hypertension Initiative Atlanta Regional Collaboration for Healthcare Improvement CDC Million Hearts American Heart Association National Association of Chronic Disease Directors	01/04/24
48723	**The Million Hearts Hypertension in Pregnancy Change Package** – Collaboration on resource to improve hypertension in pregnancy, with AMA name and logo.	Center for Disease Control and Prevention Million Hearts The Society for Maternal-Fetal Medicine The American College of Osteopathic Obstetricians and Gynecologists College of Nurse-Midwives The National Association of Nurse Practitioners in Women's Health	01/05/24
48617	**Chicago Area Public Affairs Group** – Repeat sponsorship with AMA name and logo.	Chicago Area Public Affairs Group Chicago Title Insurance Company BMO Bank JP Morgan Chase APCO Worldwide Boyce Possley The Clover Group	01/10/24
48870	**MAP Dashboards for Healthcare Organizations (HCOs)** – AMA co-branding with healthcare organizations for MAP blood pressure dashboard project.	Michigan Primary Care Association Hamilton Community Health Network Western Wayne Family Health Centers Grace Health Asian Human Services Family Health Center Concord Hospital Medical Group	01/16/24
49094	**Peterson Healthcare Technology Institute Digital Health Collaborative** – Collaboration researching benefits of digital health technology, with AMA name and logo.	Peterson Foundation AHIP National Alliance of HC Purchasers National Health Council National Partnership for Women and Families	02/02/24
49065	**Prevention Strategy Collaboration with Health Care Organizations –** Update to diabetes prevention program with AMA name and logo.	DePaul Community Health Centers Erie Family Health Centers Bedford-Stuyvesant Health Center Health Federation of Philadelphia AllianceChicago Hines VA Hospital Sparta Community Hospital University of Colorado Medicine Alabama Primary Health Care Association Hawaii Island Community Health Center East Central Mississippi Health Care Greater Philadelphia Health Action Health Partners of Western Ohio Colorado Community Managed Care Network Louisiana Primary Care Association Emplify Health	02/07/24

		Star Community Health Prosano Health Mass General Brigham Southwest Virginia Community Health Center	
49063	**American Telehealth Association Membership –** Repeat sponsorship with AMA name and logo.	American Telehealth Association	02/07/24
48981	**Access to Care Report** – Co-branded report on increasing access to care for pregnant patients with substance use disorder.	Manatt Health - Manatt, Phelps & Phillips, LLP	02/09/24
49541	**Physician Innovation Network (PIN) –** AMA PIN collaboration agreement with AMA name and logo.	RedCrow Healthcare Technology	03/08/24
49532	**AMA MAP Hypertension Quality Improvement Pilot -** Evaluation of AMA MAP program in a virtual care setting, with AMA name and logo.	KeyCare	03/14/24
49099	**Equitable Professional Societies Network Leadership Roundtables** – Health equity collaboration with healthcare leaders, with AMA name and logo.	Council of Medical Specialty Societies HealthBegins Race Forward	03/15/24
49432	**Digital Medicine Society Integrated Evidence Plans** – Toolkit collaboration with AMA name and logo.	Peterson Health Technology Institute Alliance of Community Health Plans American College of Cardiology Genentech Food & Drug Administration U.S. Department of Veterans Affairs	03/15/24
49097	**AMA Grand Rounds** – Health equity event and content collaboration with AMA and Grand Rounds name and logo.	Accreditation Council for Graduate Medical Education National Center for Interprofessional Practice and Education RespectAbility	03/18/24
49257	**Practice Transformation Survey Assessment** – AMA co-branding with healthcare organizations for physician burnout survey.	Advocate Health Care Allied Physician's Group of Riverhead Ballad Health Medical Associates Baystate Health Boulder Medical Center Carilion Clinic Cayuga Health Children's Hospital of The King's Daughters Medical Group Christus Health Cook Children's Hospital Dayton Children's Hospital Guthrie Health System Health Partners & Park Nicollet HealthONE Holland Hospital Huntington Health Jefferson Health Lahey Hospital & Medical Center Luminis Health MaineHealth Medical Group	03/25/24

		Memorial Health Ohio Methodist Mansfield Medical Center Methodist Medical Group MyMichigan Health Newark Beth Israel Medical Center Denver Health Northern Ohio Medical Specialists Northern Arizona Regional Behavioral Health Authority NYU Langone Family Health Centers Olive View, UCLA Medical Center ONCare Alliance OneHealth Saint Peter's University Hospital Schumacher Clinical Partners Health Sky Ridge Medical Center Sound Physicians South Shore Health St. Louis University SUNY Upstate Medical University Tapestry 360 Health The Guidance Center Trinity Health University of Michigan Health University of Missouri Healthcare Valley Children's Healthcare Virginia Center for Health Information Trusted Doctors Washington University School of Medicine West Virginia University Medicine Witham Hospital	
50700	**AI in Health – Navigating New Frontiers** – Working group collaboration and report on AI in Health, with AMA name and logo.	Alliance for Health Policy Kaiser Permanente Elevance Health Inc. MITRE Crowell & Moring Law The Patient-Centered Outcomes Research Institute Ostuka Pharmaceuticals Amazon Shields Health Solutions Association for Community Affiliated Plans	04/03/24
50609	**All In Campaign** – Repeat healthcare workforce wellbeing campaign with AMA name and logo.	Harvard TH Chan School of Public Health National Medical Association American Nurses Foundation AHIP Medicine Forward Institute for Healthcare Improvement American Foundation for Suicide Prevention American Society of Hospital Pharmacists	04/12/24
48927	**Validated Device Listing** – Update validatebp.org with language “a public health service supported by AMA."	National Opinion Research Center	04/13/24

62084	**Drug Shortage Task Force** - Coalition for policy recommendations to reduce drug shortage issues, with AMA name and logo.	United States Pharmacopeia Cancer Support Community Generics Access Project Association for Clinical Oncology Alliance for Aging Research Hemophilia Federation of American Friends of Cancer Research Howard University College of Pharmacy Arthritis Foundation National Consumers League National Psoriasis Foundation American Pharmacists Association Association of Health System Pharmacists Angels for Change Susan G. Komen Foundation American Cancer Society	05/28/24
62184	**Release the Pressure Coalition** – Updated coalition for collaboration on reducing hypertension in minority women, with RTP name and logo.	AMA Foundation American Heart Association National Medical Association Association of Black Cardiologists Minority Health Institute	06/04/24
62977	**Joy in Medicine** – Repeat AMA recognition program on AMA website for outstanding healthcare organizations.	Catholic Health Columbus Regional Health Common Spirit CommonSpirit Mountain Region Community Health Network Veterans Integrated Service Network Intermountain Health Memorial Healthcare System MemorialCare Medical Group Novant Health Inc NYC Health + Hospitals TMCOne VA Illiana Health Care System Children's Healthcare of Atlanta Dana-Farber Cancer Institute Bellin and Gundersen Health System HealthPartners Kansas City VA Medical Center Naples Comprehensive Health Nuvance Health Trinity Health Hospital-Ann Arbor/Trinity Health IHA Medical Group UMass Chan Medical School Baystate and Baystate Health The University of Chicago Medicine University of Kentucky College of Medicine The University of Texas Health Science Center at San Antonio Bryan Medical Center Dayton Children's Hospital Denver Health Endeavor Health Edward Hospital Endeavor Health Elmhurst Hospital El Rio Health	06/25/24

		Medical College of Wisconsin Froedtert Hospital Children's Wisconsin Hospital Hartford HealthCare Jefferson Health Johns Hopkins Medicine Mercy Health Moffitt Cancer Center MultiCare Health System MyMichigan Health Nemours Children's Health Northwell Health Oak Street Health Olive View-UCLA Medical Center Owensboro Health Pediatric Physicians' Organization Penn Medicine Lancaster General Health Roper St. Francis Healthcare Roswell Park Comprehensive Cancer Center Samaritan Health Services St. Luke's Health System Stamford Health Sutter Health Sutter Independent Physicians The Christ Hospital Health Network UMass Memorial Health University of California Irvine Health University of Mississippi Medical Center Atlantic Health System Bayhealth Hattiesburg Clinic Henry Ford Health Lehigh Valley Health Network Mid-Atlantic Permanente Medical Group Northwest Permanente The Southeast Permanente Medical Group Texas Children's Pediatrics	
63251	**Rise to Health Coalition** – Updated health equity coalition focused resources for healthcare professionals, with AMA name and logo.	Encoding Equity Alliance National League for Nursing National Council of Asian Pacific Islander Physicians Student National Medical Association US Professional Association for Transgender Health	07/12/24
64628	**National Latino Physician Day** – Awareness Campaign with AMA name and logo.	National Latino Physician Day	08/29/24
64431	**Cardiovascular Disease Prevention Collaboration** – Heart disease prevention materials and training, with AMA name and logo.	Aledade Inc.	09/03/24
64783	**CPT & Value-Based Care Collaboration** - Co-branded issue brief, with AMA name and logo.	Manatt Health, Manatt, Phelps & Phillips, LLP	09/16/24

64838	**AMA Annual Research Challenge** – Repeat annual AMA branded competition with Laurel Road sponsored prize.	Laurel Road Bank	09/18/24
65068	**AMA STEPS Forward and Value-Based Care Collaboration** – Value-based care case studies and AI governance toolkit, with AMA name and logo.	Manatt Health, Manatt, Phelps & Phillips, LLP Geisinger Health System Hattiesburg Clinic	09/24/24
64957	**Athenahealth Co-Branded Collaboration** – "Fix Medicare Now" sponsorship with AMA name and logo.	Athenahealth	09/25/24
65073	**Keep Americans Covered Program** – Coalition to extend Affordable Care Act tax subsidies, with AMA name and logo.	AHIP American Cancer Society Cancer Action Network Blue Cross Blue Shield Association Leukemia & Lymphoma Society Federation of American Hospitals American Association of Retired Persons Alliance of Community Health Plans American Academy of Family Physicians The American College of Physicians American Heart Association American Lung Association Association for Community Affiliated Plans National Association of Pediatric Nurse Practitioners National Association of Community Health Centers Families USA National Rural Health Association Small Business for America's Future Susan G. Komen Foundation Unidos US United States of Care	09/27/24
65613	**Mental Health Parity Collaboration –** Pilot for online tool comparing insurance mental health coverage, with AMA name and logo.	The Kennedy Forum Third Horizon Strategies	11/01/24
65577	**Physician Data Initiative** – Working group to establish data collection and categorization standards, with AMA name and logo.	MedBiquitous Association of American Medical Colleges Accreditation Council of Graduate Medical Education	11/04/24
66040	**Collaboration supporting CDC Million Hearts Project** – with AMA name and logo.	AllianceChicago CDC Million Hearts	11/103/24
66085	**Sponsorship supporting Physician Health Programs** – with AMA name and logo.	Federation Of State Physician Health Programs Coverys Insurance MedPro Group Medical Liability Mutual Insurance Company Physicians Insurance State Volunteer Mutual Insurance Company The Doctors Company	11/206/24

		Medical Professional Liability Association	
66163	***Academic Medicine:* Disability Supplement Collaboration** – with AMA name and logo.	Academic Medicine Association of American Medical Colleges Docs With Disabilities Initiative Robert Wood Johnson Foundation	12/18/24

MEMBER PROGRAMS

Project Number	Project Description	Corporations	Approval Date
65576	**Avid Traveling Update** - Travel affinity program with AMA name and logo.	AHI Travel Avid Traveling	10/24/24
49605	**Boards & Beyond Member Benefit** – Discount on medical student test prep materials, with AMA name and logo.	Boards & Beyond	03/12/24
66466	**AMBOSS Member Benefit** – Discount on medical student test prep materials, with AMA name and logo.	AMBOSS	12/12/24
66498	**UWorld Member Benefit** – Discount on medical student test prep materials, with AMA name and logo.	UWorld	12/16/24

BUSINESS ARRANGEMENTS/LICENSING PROGRAMS

Project Number	Project Description	Corporations	Approval Date
64865	**AMA MAP Hypertension Quality Improvement Program -** Business agreement with AMA name and logo.	Forward Health Group	10/09/24
64952	**Cadence Software Group** –AMA Guides content licensing agreement, with AMA Guides name and logo.	Cadence Software Group	12/12/24

6. TRANSPARENCY AND ACCOUNTABILITY OF HOSPITALS AND HOSPITAL SYSTEMS

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF THE REPORT FILED
See Policy D-200.971

INTRODUCTION

At the 2024 Annual Meeting of the AMA HOD, Policy D-200.971, "Transparent Reporting of Physician Complaints Against Hospitals and Health Systems" was adopted as amended, and in the first directive asked that AMA "supports and facilitates transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as The Joint Commission Quality Check reports, to include periodic report back to the HOD with the first update to be given at A-25." This report specifically addresses the report-back requirements of the first directive of this policy. The second directive of the policy is not a topic of this report

BACKGROUND:

AMA's Position

The AMA has consistently opposed making the National Practitioner Data Bank publicly available (Policy H-355.975, "Opposition to the National Practitioner Data Bank") and upheld this position in BOT Report 29-A-24, citing concerns over incomplete and inaccurate information. The AMA also opposes requiring the AMA, FSMB, The Joint Commission, or any state or federal entity to publicly disclose disciplinary actions to avoid potential misinterpretation and misuse of the data. Instead, the AMA supports state medical boards in making general information about disciplinary actions public, and the FSMB Physician Data Center, which provides information to hospitals and health care organizations about licensure history and past regulatory actions for actively licensed physicians (Policy H-355.975, "Opposition to the National Practitioner Data Bank").

The AMA has also traditionally rejected efforts to amend the HCQIA and maintained this position in BOT Report 29-A-24 where no recommendation was made to add monetary penalties for organizations involved in bad-faith peer reviews. The position to not amend the HCQIA was taken to protect the peer review process and the safety of the physicians that participate in them and prevent entities whose interests are not aligned with organized medicine from reintroducing changes that have previously been proposed. It is also a costly and challenging endeavor to provide tangible evidence that a hospital or health care organization has engaged in a bad-faith peer review. Additionally, as it currently stands, the HCQIA already does not provide immunity to organizations found to have conducted a bad-faith peer review. Further, monetary penalties at the state level have not resulted in increased reporting or reduced incident rates.[1,2]

DISCUSSION:

BOT Report 29-A-24

BOT Report 29-A-24 highlighted persistent barriers that prevent physicians from reporting patient care concerns or seeking recourse when subjected to a bad-faith peer review process. It identified interests that often prompt the initiation of bad-faith peer reviews, including retaliation for raising patient care concerns, efforts to limit competition, and racism. The report also outlined existing mechanisms for physicians to report concerns about their health system or hospital employer, as well as relevant AMA policies and resources. It recommended reaffirming these policies and urged the AMA to (1) support and facilitate transparent reporting of final physician complaints against hospitals through publicly accessible channels (e.g., the Joint Commission Quality Check reports), and (2) develop educational materials to help physicians recognize a bad-faith peer review and navigate the peer review process.

Status Update

To fulfill the AMA's responsibility to "support and facilitate transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as the Joint Commission Quality Check reports," the AMA sent a letter to the President and Chief Executive Officer of The Joint Commission,

urging the Joint Commission to facilitate transparent reporting of patient care, safety concerns, or other inappropriate practices that physician employees observe within their hospital or health system.

The letter was sent to The Joint Commission in November 2024 wherein the AMA urged them to collect and publicly share final complaint determinations related to patient and staff safety violations to contribute to efforts to improve patient safety, care quality, and assist physicians in making informed decisions about where to work. The AMA recommended that one way The Joint Commission could achieve this was by developing a new reporting tool or enhancing its existing publicly available Joint Commission Quality Check reports.

The Joint Commission's President and Chief Executive Officer promptly replied, acknowledging receipt of the letter and its important subject matter. The letter was well-received and coincided with current efforts at The Joint Commission to improve transparency around safe practices in health care organizations and their Quality Checks program.

A meeting between the AMA and The Joint Commission occurred in March 2025 to further discuss this issue. Although The Joint Commission is appreciative of the AMA's efforts, they reported that publicly disclosing details about complaints—particularly at the level of disclosing individual organization information—would run counter to the agreements and accountabilities they hold with the organizations they accredit. They are also revising their Quality Check Reports to provide additional metrics by accredited organization, but their revisions will not include information about voluntary complaints. The Joint Commission recommended that the AMA look to the state medical societies and licensing boards to collect and report on such information relevant to health care organizations in their jurisdictions. Additional recommendations discussed include continuing the promotion of existing AMA initiatives (e.g., Joy in Medicine™ Health System Recognition Program) that provide guidance for physicians assessing potential employers and staying informed on emerging employee safety metrics. The AMA will continue exploring additional avenues to facilitate transparent public reporting of physician employees' concerns related to patient or staff safety, or other serious misconduct, by hospital and health system employers.

The AMA considered sending a similar letter to the EEOC; however, since the EEOC is required by law to keep charge information confidential and is prohibited from disclosing information about charges to the public[3], no communication was sent.

RECOMMENDATIONS

The Board of Trustees recommends:

1. That the first directive of Policy D 200.971 be amended by addition and deletion as follows: Our American Medical Association supports and facilitates transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as the Joint Commission Quality Check reports and the Centers for Medicare & Medicaid Services quality websites and will report back to the HOD every two (2) years through 2029 any AMA and/or industry efforts to advance this effort. ~~to include periodic report back to the HOD with the first update to be given at A-25.~~
2. That the remainder of this report be filed.

Fiscal Note: Minimal

REFERENCES

1. Sawicki NN. State Peer Review Laws as a Tool to Incentivize Reporting to State Peer Review Laws as a Tool to Incentivize Reporting to Medical Boards Medical Boards. Loyola Univ Chic Law ECommons. Published online 2021. Accessed February 25, 2025. https://lawecommons.luc.edu/cgi/viewcontent.cgi?article=1727&context=facpubs

2. Pendo E, McIntosh T, Walsh H, Baldwin K, Dubois JM. Protecting Patients from Physicians Who Inflict Harm: New Legal Resources for State Medical Boards. J Health Law Policy. 2022;15(1). Accessed February 25, 2025. https://papers.ssrn.com/abstract=4078215.
3. U.S. Equal Employment Opportunity Commission (EEOC). Confidentiality. US EEOC. 2025. Accessed February 25, 2025. https://www.eeoc.gov/confidentiality

7. AMA PERFORMANCE, ACTIVITIES AND STATUS IN 2024

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

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

INTRODUCTION

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

Grounding our work in the Principles of Medical Ethics and the policies and wisdom of AMA House of Delegates, in 2024 the AMA was resolute in its fight to repair a broken health care system—one that is threatening the viability of physician practices and patient access to care, contributing to alarming rates of burnout and dissatisfaction, and placing enormous pressure on an already strained public health infrastructure.

Representing physicians with a unified voice

The AMA remained strongly focused on advocacy priorities critical to supporting and strengthening our nation's physician workforce and improving the lives of patients.

Thanks to the AMA's year-long push to reform an unsustainable Medicare reimbursement model that has cut physician payment by 33 percent since 2001, policymakers in Washington, D.C., now understand and acknowledge the crisis and are working in a bipartisan fashion on permanent solutions aligned with AMA recommendations.

The AMA's "Fix Medicare Now" grassroots campaign, which received widespread media attention, generated more than half-million contacts to members of Congress and helped secure introduction of two important pieces of federal legislation to reform the Medicare payment system.

- H.R. 2474, which would enact an annual, permanent inflationary payment update in Medicare that is tied to the Medicare Economic Index
- H.R. 6371, which would reform the budget neutrality policies that have been producing across-the-board payment cuts

Similarly, the AMA's advocacy campaign to reform the onerous prior authorization process, including its "Fix Prior Auth" grassroots campaign, resulted in important reforms both at the federal level and in more than a dozen states.

- The Centers for Medicare & Medicaid Services released final regulations to cut patient care delays and electronically streamline the prior authorization process for physicians—saving physicians an estimated $15 billion dollars.
- At the state level, over a dozen states enacted prior authorization reform laws—supported by the AMA and state medical associations.

In the courts, the AMA was a critical voice for physicians and organized medicine on a broad range of public health issues, including restricting access to e-cigarettes, tougher regulation of unlicensed and untraceable "ghost" guns, and expanding access to care. In addition to defending physicians from criminal and civil penalties for providing necessary care, the AMA was a plaintiff in a major antitrust case against MultiPlan, a data analytics company accused of creating a price-fixing conspiracy with the largest commercial health insurance companies in the country.

The AMA worked alongside state medical associations from across the country to oppose inappropriate scope expansions in more than 40 states. Much of the success was bolstered by the "AMA Scope of Practice Partnership" initiative that has provided more than $4 million in grants since its inception.

The AMA's efforts helped deliver concrete results in protecting patients from inappropriate scope of practice expansions, including the defeat of over 80 bills that would have allowed:

- Physician assistants and nurse practitioners to independently practice medicine
- Pharmacists to independently diagnose and prescribe medications to patients
- Naturopaths to prescribe legend drugs or perform surgical procedures
- Optometrists to perform surgery
- Nurse anesthetists to provide anesthesia services without physician supervision
- Psychologists to independently prescribe medications

Through proactive strategies and reactive opportunities, the AMA elevated the voice of physician leadership on critical issues of public health and our priority topics with media clips exceeding our three-year average. This includes the work to avert the Medicare payment cuts, as well as media and speech visibility throughout the year, leading to more than 3.8 billion media impressions (up from two billion in 2023 and a 10X increase from 2021). Meanwhile, our prior authorization legislation is on the precipice of passing, due to this sustained topic of visibility over the past decade, including 4.7 billion media impressions in 2024 (up from 2.3 billion in 2023)

Removing obstacles that interfere with patient care

Support for physician mental health and well-being expanded in 2024 as the AMA led, funded, or contributed to 38 research projects either to address burnout, promote digital health solutions or aid the long-term sustainability of physician practices. The AMA also recognized 62 health systems for implementing evidence-based strategies to improve physician and health provider well-being through the AMA's Joy in Medicine™ Health System Recognition Program.

Guided by the AMA and in support of physician well-being, a total of 34 licensure boards as of 2024—including 29 medical boards, and more than 425 hospitals and health systems—have revised their licensing or credentialing applications to remove intrusive mental health questions and stigmatizing language. This result is due to an ongoing advocacy effort by the AMA and our close partnerships with organizations like the Dr. Lorna Breen Heroes' Foundation.

AMA STEPS Forward® developed over 90 new or updated resources focused on preventing physician burnout, creating the organizational foundation for joy in medicine, and improving practice efficiency. The resources include toolkits, webinars, podcast episodes, and the new "Reducing Regulatory Burden and Value of Feeling Valued" playbooks.

To expand insight into burdensome electronic health record (EHR) systems, the AMA awarded grants to five organizations through the AMA Electronic Health Record Use Research Grant Program to study EHR usage and improve workflow and resource allocation at the practice and system-level.

The AMA conducted research to explore the role of Current Procedural Terminology (CPT®) in value-based care. Among other vital information, the research identified crucial ways that help ensure the CPT code set remains relevant as value-based care continues to evolve in health care delivery.

To help eliminate obstacles to patient care, the AMA launched VeriCre™, which streamlines the credentialing process, improves efficiency and reduces redundancy for physicians, hospitals, and health plans allowing patients to receive care sooner. VeriCre™ allows physicians to easily manage their credentials, career information and forms for efficient distribution and secure integration with third-party credentialing software.

Driving the future of medicine

To help physicians assess the risks and opportunities of augmented intelligence (AI) in medicine, the AMA continued to develop tools, resources, and support for AI study and implementation, and elevated the most pressing concerns of physicians to those shaping our digital health future.

Underscoring our commitment to ensure the physician voice is integrated into all aspects of health care technology, the AMA released an AI landscape report that provides an overview of current and future use cases, potential

applications, and opportunities and risks of AI. The AMA also presented three webinars on future health topics including digital empathy, the human factor in solving problems, and navigating AI in health care.

JAMA® hosted the second annual *JAMA* Summit™, which convenes leaders from across sectors and around the world to discuss and debate critical issues in medicine, health, and health care. This year's event focused on the integration of AI in clinical medicine. *JAMA*® created and launched JAMA+ AI, a channel devoted as the first stop for authors and readers seeking the best science and commentary on AI and its application to medicine and public health.

The AMA, in partnership with the University of Michigan, developed a new seven-part online activity series "AI in Health Care," which introduces learners to foundational principles of AI and machine-learning.

As a leader in the advancement of precision education, the AMA concluded the 2024 AMA ChangeMedEd® Innovation Grant Program that awarded 13 grants and focused on the application of precision education across the medical education continuum—from medical school and residency to continuing medical education. The AMA continued to further define precision education as a critical way to develop an effective model of lifelong learning in medical education, one which produces a physician workforce capable of caring for our patients, families, and communities.

AMA Ed Hub™ partners with more than 60 organizations as a vital source of professional education for physicians by providing trusted, high-quality education to enable lifelong professional development. In 2024, AMA Ed Hub™ continued to experience high engagement.

- 8000+ education activities available
- 475,000+ registered users
- 4 million visitor sessions
- 600,000 courses completed

Leading the charge to confront public health crises

To address systemic inequities that have contributed to poorer health outcomes for historically marginalized communities, the AMA reaffirmed its commitment to health equity by extending our multi-faceted health equity strategic plan through 2025. This work spans state and federal advocacy, education and training for physicians, and community investments that target the root causes of inequities in medicine and help all people achieve their optimal health.

In collaboration with more than 20 organizations, the AMA hosted two National Health Equity Grand Rounds, which featured 14 national experts and reached over 24,000 viewers.

Building on its long legacy of advancing public health, 2024 saw the AMA develop a new strategic approach for promoting greater blood pressure control in targeting the number one cause of premature death in the U.S.: heart disease. By engaging more than 280 health care organizations the AMA helped reach more than 2.5 million hypertensive patients with solutions that assisted physicians and care teams in lowering their patients' blood pressure risks.

Amid the rising rates of sexually transmitted infections and viral hepatitis across the U.S., the AMA, in collaboration with the Centers for Disease Control and Prevention (CDC), launched a new online toolkit to help physicians and other health care professionals increase routine screenings for human immunodeficiency virus, sexually transmitted infections, viral hepatitis, and latent tuberculosis. We also hosted a series of educational webinars about best practices and strategies for routine screening.

The CDC's National Partners Cooperative Agreement awarded the AMA $2.45 million to support our efforts in advancing hypertension and cholesterol care in communities across the U.S.

The AMA's Enterprise Social Responsibility (ESR) program celebrated its fifth year of working to reduce health inequities in partnership with communities. AMA's ESR program aligns with the needs of the organizations through active partnerships, where AMA's activities are recognized as collaborative and add value to the community. In 2024, the ESR program recorded the most impactful year to date hosting over 40 events, supporting 85 organizations.

Membership

The AMA's advocacy and mission activities were again fueled by another year of strong financial performance and continued membership growth. AMA membership has increased more than 40 percent in the last 15 years with a 3.1 percent increase in dues paying members in 2024 alone as more physicians, medical students, and residents recognize our efforts and want to join the AMA in fighting on their behalf.

EVP Compensation

During 2024, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was $1,400,311 in salary and $1,262,299 in incentive compensation, reduced by $2,902 in pre-tax deductions. Other taxable amounts per the contract are as follows: $168,999 distribution from a deferred compensation plan; $23,484 imputed costs for life insurance, $24,720 imputed costs for executive life insurance, $22,865 for legal fee reimbursement, $2,820 paid for parking and $2,500 paid for a fitness facility.

For additional information about AMA activities and accomplishments, please see the "AMA 2024 Annual Report."

8. ANNUAL UPDATE ON ACTIVITIES AND PROGRESS IN TOBACCO CONTROL: MARCH 2024 THROUGH FEBRUARY 2025

Informational report; no reference committee hearing

HOUSE ACTION: FILED

This report summarizes trends and news on tobacco usage, policies, and tobacco control advocacy activities from March 2024 through February 2025. The report is written pursuant to American Medical Association (AMA) Policy D-490.983, "Annual Tobacco Report."

TOBACCO USE AT A GLANCE*

Adult smoking rates are at an all-time low of 11 percent and yet it is still the leading cause of preventable death in the United States. According to U.S. Surgeon General, one in five of all deaths are caused by smoking.[1] According to the Centers for Disease Control and Prevention (CDC) cigarette smoking accounts for more than 480,000 deaths every year, or about one in five deaths. Chronic diseases associated with cigarette smoking include respiratory and cardiovascular diseases, cancers, and diabetes. More than 16 million Americans live with a smoking-related disease.[2]

Despite large absolute differences in the numbers of smoking-attributable deaths by race and ethnicity, smoking accounts for a similar proportion of deaths among non-Hispanic Black (18 percent) and non-Hispanic White (20 percent) people and for approximately 10 percent of deaths among Hispanic people. In January 2025, Health and Human Services released the 35th United States Surgeon General's report on tobacco, Eliminating Tobacco-Related Disease and Death: Addressing Disparities. The report documents the persistence of disparities in tobacco product use and exposure to secondhand tobacco smoke and outlines recommendations that include marketing and manufacturing restrictions, funding for evidence-based programs and cessation inventions and eliminating menthol and flavorings in all tobacco products.[1]

Cigarettes remain the most commonly used type of tobacco product followed by e-cigarettes. Although cigarette smoking rates decreased, e-cigarette use increased from 3.7 percent in 2020 to 6.5 percent in 2023 according to National Health Interview Survey.[3] Men were more likely than women to use e-cigarettes. In 2019 3.5 percent of women and 5.5 percent of men reported using e-cigarettes. This increased to 5.5 percent and 7.6 percent in 2023. Examining usage by different age groups in 2023, e-cigarette usage was highest in adults ages 21-24 (15.5 percent), with usage decreasing with increased age among those 25 and older.

Current use of any tobacco product among middle and high school declined overall according to an analysis of the 2024 National Youth Tobacco Survey (NYTS) from 10 percent in 2023 to 8.1 percent in 2024. The analysis was published in the October 17, 2024, Morbidity and Mortality Weekly Report (MMWR).[4] The overall declines were largely driven by the decline in high school e-cigarette use that went from 1.56 million in 2023 to 1.2 million in 2024.

But despite the declines one in 10 high school students and one in 20 middle school students reported current tobacco use of any product in 2024.

E-cigarette products were the most used tobacco product of middle and high school students with 5.9 percent reporting current e-cigarette use followed by nicotine pouches (1.8 percent), and cigarettes (1.4 percent). Among students who had ever used an e-cigarette, 43.6 percent reported current use. Tobacco use declined for Hispanic students and remained stable for other racial and ethnic groups but increased for non-Hispanic American Indian or Alaska Native. The continued disparities among youth tobacco users reported in the analysis highlights the need to continue to develop targeted prevention and control interventions.

NYTS is a cross-sectional, voluntary, school-based, self-administered, Internet survey of U.S. middle school (grades 6–8) and high school (grades 9–12) 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 and high schools. Data were collected during January 22–May 22, 2024; 29,861 students from 283 schools participated, with an overall response rate of 33.4 percent.

EFFORTS TO ADDRESS TOBACCO CONTROL

Medicaid coverage improves for tobacco cessation, but barriers still exist

More than one in five adults enrolled in Medicaid smoke cigarettes which is higher than adults with private insurance. In 2021, prevalence in adults enrolled in Medicaid was 21.5 percent compared to 8.6 percent enrolled in private insurance. According to a report, State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Accessing Treatments — United States, 2018–2022, the number of states with comprehensive Medicaid coverage of tobacco cessation treatment increased from 15 to 20 states.[5]

The American Lung Association (ALA) authored the report that analyzed state-level information looking at coverage for nine tobacco cessation treatments and access barriers which include co-payments, prior authorization, treatment duration, annual and lifetime limits, and two others. The biggest improvement in removing barriers was for co-payments with nearly a third of the states without this requirement. The authors credit the enactment of the Families First Coronavirus Response Act which increased the federal share of Medicaid spending and required states to limit new cost-sharing for Medicaid enrollees.

Low-income populations are disproportionately affected by smoking-related diseases. Smoking cessation is one of the most effective interventions to prevent the health risks associated with chronic diseases.[6] Removing barriers to cessation services would improve quality of life as well as reduce the direct and indirect costs of tobacco-related diseases.

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 amicus briefs after their laws banning flavored tobacco products and ENDS have been challenged by the tobacco and vaping industry.

Notably, the AMA Litigation Center joined two amicus briefs in the United States Supreme Court involving marketing denial orders of flavored products under the Tobacco Control Act. The two cases, Federal and Drug Administration (FDA) v. Wages and Lion Investments and FDA v. R.J. Reynolds Vapor, have been briefed and argued and the Court is expected to rule before the end of June 2025.

In 2020, the AMA joined the African American Tobacco Control Leadership Council (AATCLC) as a plaintiff in its lawsuit against the Department of Health and Human Services and the FDA on account of the FDA's failure to prohibit the sale of menthol-flavored cigarettes. An FDA report found menthol cigarette use is associated with increased smoking initiation among youth and young adults, greater signs of nicotine dependence, and less success in smoking cessation. As of June 2024, the FDA had still not released rules for prohibiting the sale of menthol-flavored cigarettes. In January 2025, the Trump Administration withdrew the proposed federal rule banning menthol flavoring. This

AMA/AATCLC lawsuit continues with Action on Smoking and Health and National Medical Association joining the suit.

California rolls back secondhand smoke protections

Public health and medical organizations were stunned when California Governor Gavin Newsom signed Assembly Bill 1775 (AB 1775) into law in September 2024. This law expands what is permitted at cannabis/marijuana retailers. Existing law gives California cities and counties the authority to decide if cannabis retailers are permitted in the jurisdiction, and to decide whether those cannabis retailers may allow onsite use, such as indoor cannabis smoking and/or vaping.

According to the Americans for Nonsmokers Rights the new law, which went into effect January 1, 2025, goes a step further by allowing jurisdictions to permit an additional element at cannabis retailers: the sale of food and non-alcoholic beverages and the sale of tickets to performances. This law, one of the first in the country, rolls back California's leadership in protecting workers from the health risks associated with secondhand smoke exposure which includes cannabis smoke. In fact, Governor Newsom had vetoed a similar law the previous year but succumbed to pressure from the rising influence of the cannabis lobby. [7,8,9]

Tobacco control advocates will continue to work at the local level to call for restrictions on cannabis retailers while working at the state level to overturn AB 1775.

American Lung Association Releases its 2025 State of Tobacco Report

The ALA released its 2025 "State of Tobacco Control" (https://www.lung.org/research/sotc) which reviews tobacco control activities at the state and federal levels and assigns grades based on laws and regulations designed to prevent and reduce tobacco use including e-cigarettes.[10] This is the 23rd edition of the ALA's State of Tobacco report which has served as a blueprint to public health organizations, and local, state and federal governments for enacting proven tobacco control policies. The 2025 report reveals the continued impact of tobacco use, including menthol cigarettes, on individuals and families across the country, and underscores the continued influence of the tobacco industry. These include tobacco industry efforts to stop former President Biden from ending the sale of menthol cigarettes and flavored cigars as well as industry efforts at the state level to stop proven-effective policies to prevent and reduce tobacco use.

Four states, Alabama, Georgia, Mississippi and Texas, received the worst grades in the nation. These states either did not advance any policies or weakened existing tobacco control efforts. Every state received an F for failing to pass any legislation or regulation prohibiting the sales of flavored tobacco products. The variety of flavors available for use in e-cigarettes has grown exponentially, especially among youth and young adults, according to a Tobacco Free Kids issue brief.[11] The city of Denver passed a comprehensive flavored tobacco law, again demonstrating the leadership of local communities on this issue.

Maryland was lauded for increasing its cigarette tax by $1.25 per pack, making it the second highest state cigarette tax in the country at $5.00 per pack. Tobacco taxation, passed on to consumers in the form of higher cigarette prices, is one of the most effective population-based strategies for decreasing smoking and its adverse health consequences.[12]

Effective September 2024, 21 is the national tobacco sales age

After almost four years of delay, stricter requirements for tobacco retailers were finalized by the FDA in August 2024. In accordance with the 2019 passage of the Tobacco 21 legislation, the FDA issued final rules that became effective September 30, 2024, requiring retailers to use a photo ID to verify the age of anyone under the age of 30 trying to purchase any tobacco product including smokeless. In addition, the rules prohibit tobacco product vending machines in facilities where individuals under 21 are present or are permitted to enter. In 2019 Senators Tim Kaine (D-VA) and Mitch McConnell (R-KY) worked together to pass the Tobacco 21 law which also called for the FDA to issue guidance on implementation and enforcement. In 2022 they called on then FDA Commissioner Dr. Robert Califf to provide greater transparency on delays.[13] It is estimated that raising the minimum legal age to 21 years would reduce the smoking initiation rate among 15- to 17-year-olds by 25 percent, lead to 50 000 fewer cases of lung cancer and prevent 223 000 early deaths in the US.[14, 15]

*Note – at the time this report was prepared updated tobacco/smoking related data and reports were unavailable from trusted government sources. Due to the Trump Administration Executive Orders, CDC and other agencies were required to remove sources of public health surveillance data and reports.

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9. COUNCIL ON LEGISLATION SUNSET REVIEW OF 2014 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED

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

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

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

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

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

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

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

RECOMMENDATION

The Board of Trustees recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated, except for Policy D-40.990, which should be retained, and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-105.995	Protecting Social Media Users by Updating FDA Guidelines	Our AMA will lobby the Food and Drug Administration to: (1) update regulations to ensure closer regulation of paid endorsements of drugs or medical devices by individuals on social media; and (2) develop guidelines to ensure that compensated parties on social media websites provide information that includes the risks and benefits of specific drugs or medical devices and off-use	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		prescribing in every related social media communication in a manner consistent with advertisement guidelines on traditional media forms.	
D-130.976	Implications of the November 2003 Emergency Medical Treatment and Labor Act (EMTALA) Final Rule	Our AMA will: (1) ask the EMTALA Technical Advisory Group (TAG) and the Centers for Medicare and Medicaid Services (CMS) for assistance in ameliorating the differential economic and staffing burdens on certain categories of facilities, including but not limited to academic health centers, trauma centers, critical access hospitals, and safety net hospitals, which are likely to receive high volumes of patients as a result of the EMTALA regulations; (2) work with the EMTALA TAG and CMS to ensure that physicians staffing emergency departments and on-call emergency services be appropriately compensated for providing EMTALA mandated services; (3) with input from all interested Federation members, coordinate an effort to educate the membership about emergency department coverage issues and the efforts to resolve them; (4) seek to require all insurers, both public and private, to pay promptly and fairly all claims for services mandated by EMTALA for all plans they offer, or face fines and penalties comparable to those imposed on providers; and (5) seek to have CMS require all states participating in Medicaid, as a condition of continued participation, establish and adequately fund state Emergency Medical Services funds which physicians providing EMTALA-mandated services may bill, and from which those physicians shall receive prompt and fair compensation.	Retain – this policy remains relevant.
D-165.961	Physician Taxes	Our AMA will (1) proactively and vigorously oppose taxes on physician services, physician-owned facility taxes or "pass-through" taxes on medical services; and (2) work closely with national specialty societies and state medical societies to assist with advocacy efforts to combat existing and proposed taxes on physician services and physician-owned facilities.	Retain – this policy remains relevant.
D-165.989	Managed Care Organization Reimbursement Formulas	Our AMA will continue to assist states medical associations in their efforts to enact meaningful legislation that protects patients and patient access through network adequacy provisions.	Retain – this policy remains relevant.
D-180.998	Insurance Parity for Mental Health and Psychiatry	Our AMA in conjunction with the American Psychiatric Association and other interested organizations will develop model state	Sunset this policy.

Policy Number	Title	Text	Recommendation
		legislation for the use of state medical associations and specialty societies to promote legislative changes assuring parity for the coverage of mental illness, alcoholism, and substance abuse.	The AMA worked with the American Psychiatric Association and other organizations to develop and promote model state legislation that has been successfully enacted in multiple states and provisions have been introduced in at least four states in the 2025 state legislative sessions.
D-185.999	Information Included On Health Insurance Identification Cards	Our AMA will continue to work with payers, the federal and state governments, and standards organizations to adopt and implement appropriate policies, technologies (e.g., smart cards, telephone hot lines, electronic data interchange, and website access), and national technology standards to provide physicians with accurate and real time verification of patient eligibility, co-payment due, deductible payable information, and claims processing.	Retain – this policy remains relevant.
D-260.993	~~Opposition to Laboratory Reporting Provisions of H.R. 4302~~ Laboratory Reporting Burdens	Our American Medical Association will work with federation members and other major stakeholders, including the clinical laboratory and hospital associations, to identify and pursue viable congressional and regulatory strategies to eliminate or substantially reduce the reporting burden associated with Medicare rate setting for laboratory fee schedule services and procedures while supporting access to clinical laboratory services among the spectrum of providers of these services.	Retain – this policy remains relevant.
D-265.990	Strategic Lawsuits Against Public Participation (SLAPP)	Our AMA will make available, but not as a matter of advocacy priority, model anti-SLAPP legislation protecting physicians' ~~physicians?~~ First Amendment rights in the context of proceedings relating to quality of health care.	Retain – this policy remains relevant.
D-270.995	Physician Ownership and Referral for Imaging Services	Our AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary exception to physician self-referral laws, including as they apply to imaging services.	Retain – this policy remains relevant.
D-275.955	MOC Provisions of Interstate Medical Licensure Compact	Our American Medical Association will, in collaboration with the Federation of State Medical Boards and interested state medical boards, request a clarifying statement from the Interstate Medical Licensure Compact Commission that the intent of the language in the model legislation requiring that a physician "holds" specialty certification	Sunset this policy. This directive has been accomplished. In 2015, the AMA requested a clarifying statement from the Interstate Medical Licensure Compact Commission (IMLCC) as

Policy Number	Title	Text	Recommendation
		refers only to initial specialty certification recognized by the American Board of Medical Specialties or the American Osteopathic Association's (AOA's) Bureau of Osteopathic Specialists and that there is no requirement for participation in ABMS's Maintenance of Certification or AOA's Osteopathic Continuous Certification (OCC) program in order to receive initial or continued licensure under the Interstate Medical Licensure Compact.	specified in this directive. In a response letter, the IMLCC clarified that a physician must hold specialty certification at the time of their application to the Compact but is not required to participate in MOC or OCC. The letter stated that the Compact does not have any language requiring that physicians participate in MOC or OCC and has no requirement for continued certification beyond the initial authorization of licensure.
D-285.963	Out of Network Coverage Denials for Physician Prescriptions and Ordered Services	Our American Medical Association will pursue regulation or legislation to prohibit any insurer from writing individual or group policies which deny or unreasonably delay coverage of medically necessary prescription drugs or services based on network distinctions of the licensed health care provider ordering the drug or service.	Retain – this policy remains relevant.
D-305.955	Funding for Teaching Health Center Graduate Medical Education Program	Our American Medical Association will encourage Congress to reauthorize the Teaching Health Center Graduate Medical Educational Program to its full and ongoing funding needs to continue the training of primary providers in community based health centers in underserved areas to assure a continuing supply of primary providers and dentists for the underserved populations.	Retain – this policy remains relevant.
D-315.977	Indemnity for Breaches in Electronic Health Record Cybersecurity	Our AMA will advocate for indemnity or other liability protections for physicians whose electronic health record data and other electronic medical systems become the victim of security compromises.	Retain – this policy remains relevant.
D-315.978	Protecting Consumers' Personal Data	Our AMA supports legislation that prohibits the inappropriate sharing of health and other personal information obtained from health insurance marketplaces.	Retain – this policy remains relevant.
D-330.907	Protect Medicare Beneficiary Access to Complex Rehabilitation Wheelchairs	Our AMA strongly encourages the Centers for Medicare and Medicaid Services (CMS) to refrain from implementing policies on January 1, 2016 that would curtail access to complex rehabilitation technology (CRT) wheelchairs and accessories by applying competitively bid prices to these specialized devices. In the event that CMS does not refrain from implementing policies limiting access to CRT wheelchairs, our AMA will encourage Congress to support legislation (e.g. H.R. 3229) that would provide a	Sunset this policy. This policy has been accomplished. The 2022 Inpatient Rehabilitation Facility final rule permanently exempted (across all settings) complex rehabilitation technology wheelchairs and accessories from Medicare's competitive bidding program.

Policy Number	Title	Text	Recommendation
		technical correction to federal law to clarify that CMS cannot apply Medicare competitive bidding pricing to CRT wheelchairs.	
D-330.908	Improving the Local Coverage Determination Process	1. Our AMA will advocate through legislative and/or regulatory efforts as follows: A. When Medicare Administrative Contractors (MACs) propose new or revised Local Coverage Determinations (LCDs) said Contractors must: (1) Ensure that Carrier Advisory Committee meeting minutes are recorded and posted to the Contractor's website; and (2) Disclose the rationale for the LCD, including the evidence upon which it is based when releasing an approved LCD; B. That the Centers for Medicare and Medicaid Services adopt a new LCD reconsideration process that allows for an independent review of a MAC's payment policies by a third-party, with appropriate medical and specialty expertise, empowered to make recommendations to the Secretary of Health and Human Services that said policies should be withdrawn or revised; and C. That MACs shall be prohibited from adopting another MAC's LCD without first undertaking a full and independent review of the underlying science and necessity of such LCD in their jurisdiction. 2. Our AMA will work with interested state medical and national specialty societies to develop model legislation or regulations requiring commercial insurance companies, state Medicaid agencies, or third party payers to: A. Publish all edits that are to be used in their claims processing in a manner that is freely accessible and downloadable to physicians; and B. Participate in a transparent process that allows for review, challenge, and deletion of unfair edits.	Retain – this policy remains relevant.
D-330.944	Admission Criteria for Inpatient Rehabilitation Services	Our AMA will seek a legislative change to the admission criteria for Inpatient Rehabilitation Facilities to diagnosis-specific, functional-level and limitations of the individual patient as opposed to diagnosis-specific criteria alone.	Sunset this policy. The intent of this policy has been realized through regulatory updates to the 2017 Inpatient Rehabilitation Facilities (IRF) Reference Booklet, which outlines both diagnosis-specific and functional-level assessments in determining IRF admissions.
D-330.948	Medicare Demonstration Projects	Our AMA will: (1) encourage CMS to continue to seek input at the earliest possible occurrence from medical associations in the	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		development of Medicare demonstration projects that are intended to contain costs and/or improve the appropriateness or quality of patient care; (2) encourage CMS to continue to vary the types of physician practices (e.g., by size, geographic location) that it utilizes in its Medicare demonstration projects; (3) encourage CMS to limit requirements that may make participation in Medicare demonstration projects financially and/or administratively impracticable for a wide range of physician practices; and (4) join state and specialty societies early on to assist with developing Medicare demonstration projects to protect the interests of patients and physicians.	
D-35.982	AMA Support for States in Their Development of Legislation to Support Physician-Led, Team Based Care	1. Our AMA will continue to assist states in opposing legislation that would allow for the independent practice of certified registered nurse practitioners. 2. Our AMA will assist state medical societies and specialty organizations that seek to enact legislation that would define the valued role of mid-level and other health care professionals within a physician-led team based model structured to efficiently deliver optimal quality patient care and to assure patient safety. 3. Our AMA will actively oppose health care teams that are not physician-led.	Retain – this policy remains relevant.
D-383.980	Health Care Entity Consolidation	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.	Retain – this policy remains relevant.
D-385.974	Freedom of Practice in Medical Imaging	Our AMA will: (1) encourage and support collaborative specialty development and review of any appropriateness criteria, practice guidelines, technical standards, and accreditation programs, particularly as Congress, federal agencies and third party payers consider their use as a condition of payment, and to use the AMA Code of Ethics as the guiding code of ethics in the development of such policy; (2) actively oppose efforts by private payers,	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		hospitals, Congress, state legislatures, and the Administration to impose policies designed to control utilization and costs of medical services unless those policies can be proven to achieve cost savings and improve quality while not curtailing appropriate growth and without compromising patient access or quality of care; (3) actively oppose efforts to require patients to receive imaging services at imaging centers that are mandated to require specific medical specialty supervision and support patients receiving imaging services at facilities where appropriately trained medical specialists can perform and interpret imaging services regardless of medical specialty; and (4) actively oppose any attempts by federal and state legislators, regulatory bodies, hospitals, private and government payers, and others to restrict reimbursement for imaging procedures based on physician specialty, and continue to support the reimbursement of imaging procedures being performed and interpreted by physicians based on the proper indications for the procedure and the qualifications and training of the imaging specialists in that specific imaging technique regardless of their medical specialty.	
D-390.952	96-Hour Rule for Critical Access Hospitals	1. Our American Medical Association will support and lobby for passage of legislation that would provide relief to Critical Access Hospitals from the "96-hour rule." 2. Our AMA will join with other affected stakeholders to enhance efforts for passage of legislation that would provide relief to Critical Access Hospitals from the "96-hour rule."	Retain – this policy remains relevant.
D-390.979	Economic Impact of Shifts in Site of Service	Our AMA will strongly advocate that, should the Sustainable Growth Rate formula continue to be used, the Centers for Medicare and Medicaid Services increase the SGR target to take into account procedures that are newly priced in the office setting, and continue to analyze the shift in site of service of these procedures to determine if the SGR target adjustments are accurate.	Sunset this policy. This policy is outdated. The SGR formula was permanently repealed in 2015 with the passage of the Medicare Access and CHIP Reauthorization Act.
D-40.990	~~Support for the Veterans to Paramedics Transition Act of 2015~~ Support for Pathways for Veterans to	Our AMA supports legislation to enable veterans who desire to serve as paramedics to obtain training to satisfy emergency medical services personnel certification requirements, taking into account previous medical	~~Sunset this policy.~~ ~~The Veterans to Paramedics Transition Act of 2015 has not been reintroduced since 2015.~~

Policy Number	Title	Text	Recommendation
	Transition to Paramedics	coursework and training received when such veterans were members of the armed forces.	Retain with title change
D-410.995	Fairness in Medical Imaging Interpretation	1. Our AMA will continue to work with specialty societies and CMS to ensure that fair Medicare accreditation standards for advanced imaging services are adopted by the selected accrediting organizations. ~~2. Our AMA will encourage Congress and the Administration to allow the MIPPA-mandated Medicare accreditation program to be fully implemented and evaluated before further changes to Medicare's imaging standards and payments are made.~~ ~~3. Our AMA will monitor the two-year Medicare appropriateness program, scheduled to begin in 2010, and work with specialty societies and the CMS to develop appropriateness (and exceptions) criteria if it decides to move forward with a permanent program.~~ 42. Our AMA will continue to work with specialty societies to correct payer and RBM policies that unfairly exclude qualified physicians from providing imaging services.	Retain this policy in part. Delete clauses 2 and 3. The MIPPA accreditation program has been fully implemented and the two-year Medicare appropriateness program ended over a decade ago.
D-435.969	Liability Related to Referrals from Free Clinics	That our American Medical Association will work with interested medical associations to enact state legislation that provides medical liability immunity, similar to the protections granted under the Federal Tort Claims Act (FTCA), to physicians who provide charity care in hospitals, offices, clinics or other health care settings to patients referred from free clinics.	Retain – this policy remains relevant.
D-435.980	Inclusion of Residents in Medical Liability Reform	Our AMA: (1) officially supports the inclusion of all physicians, including unlicensed residents, in state and federal medical liability caps; (2) will advocate for the inclusion of unlicensed residents in all pending and future federal medical liability reform legislation; and (3) will work with state medical societies to advocate for the inclusion of unlicensed residents in all current, pending, and future state medical liability reform legislation.	Retain – this policy remains relevant.
D-450.964	Medicare Quality and Resource Use Reports	Our AMA will continue to work with the Centers for Medicare & Medicaid Services to improve the design, content, and performance indicators included in the Quality and Resource Use Reports (QRURs) for physicians, so that the reports reflect the quality and cost data associated with these	Sunset this policy. The QRURs and VBM program were discontinued after December 31, 2018, after the transition to the Merit-based Incentive Payment System.

Policy Number	Title	Text	Recommendation
		physicians in calculating Value-Based Payment Modifiers (VBM).	
D-450.967	The PQRI Reporting Standard Should be Amended	Our AMA will petition the Centers for Medicaid and Medicare Services to streamline and make less arduous the reporting standard of the Physicians' Quality Reporting Initiative and ask Congress to delay implementation of the mandatory nature of the program until the system has been refined to be more efficient and physician friendly.	Sunset this policy. The Physicians' Quality Reporting Initiative was discontinued and replaced by the Merit-based Incentive Payment System.
D-95.975	Physician Self-Monitoring of Controlled Substance Prescriptions	Our American Medical Association will work with the National Alliance for Model State Drug Laws (NAMSDL), as well as other appropriate national organizations and stakeholders, to update the NAMSDL's Model Prescription Monitoring Program Act to provide health care professionals the opportunity to review their schedule 2-5 controlled substance prescribing patterns as a means to help monitor appropriate prescribing and detect and identify fraudulent prescriptions dispensed under their respective Drug Enforcement Administration numbers.	Sunset this policy. Every state now has a functional Prescription Drug Monitoring Program, and there are procedures to permit an authorized user the opportunity to review their prescribing history.
H-120.939	Physicians Should be Able to Cancel or Rescind Renewals of Prescriptions After the Prescription has Been Delivered to the Pharmacy	Our AMA will support legislation or regulations that: (i) authorize physicians to cancel or rescind renewals of prescriptions previously written; (ii) mandate pharmacies, including pharmacy benefit plans, to implement easy-to- use procedures to permit physicians to issue orders to cancel or rescind renewals of prescriptions previously written; (iii) prevent such renewals from being filled or mailed to the patient; and (iv) enable the pharmacy or pharmacy benefit plan to readily implement such renewal orders, when directed by the physician, regardless of the state of residence of the patient, the state of practice or licensure of the physicians, and the state of business operation of the pharmacy or the pharmacy benefit plan.	Retain – this policy remains relevant.
H-120.955	Non-Physician Prescribing	1. Our AMA advocates that prescriptive authority include the responsibility to monitor the effects of the medication and to attend to problems associated with-the use of the medication. This responsibility includes the liability for such actions. 2. Our AMA supports the development of methodologically valid research on the relative impact of non-physician prescribing on the quality of health care.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-130.941	Legal Issues Surrounding the Deployment and Utilization of Licensed Physicians in Response to Declared Disasters	Our AMA: (1) encourages physicians who are interested in volunteering during a disaster to register with their state's Emergency System for Advance Registration of Volunteer Health Professionals program, local Medical Reserve Corps unit, or similar registration systems capable of verifying that practitioners are licensed and in good standing at the time of deployment; and (2) (a) supports the National Conference of Commissioners on Uniform State Laws (NCCUSL) Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) with the liability language of Alternative A; and (b) continues to advocate for civil liability protections for qualified physicians that provide care in a disaster who are not covered under the UEVHPA, but are covered in AMA model legislation titled "To Protect Physicians from Civil Liability Arising from Health Care Provided During a Disaster."	Retain – this policy remains relevant.
H-140.861	Physicians' Self-Referral	Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession. In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships--including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices--are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:(1) Ensure that referrals are based on objective, medically relevant criteria. (2) Ensure that the arrangement: (a) is structured to enhance access to appropriate, high quality health care services	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		or products; (b) within the constraints of applicable law: (i) does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation; (ii) does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and (iii) adheres to fair business practices vis-a-vis the medical professional community--for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians. (3) Take steps to mitigate conflicts of interest, including: (a) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products; (b) establishing mechanisms for utilization review to monitor referral practices; and (c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated. (4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.	
H-140.874	Opposition to Legislation that Presumes to Prescribe Patients' Preferences for Artificial Hydration and Nutrition	Our AMA opposes legislation that would presume to prescribe the patient's preferences for artificial hydration and nutrition in situations where the patient lacks decision-making capacity and an advance directive or living will.	Retain – this policy remains relevant.
H-180.947	Maintaining Freedom of Choice with Insurance Products	Our AMA opposes consolidation in the health insurance industry that may result in anticompetitive markets.	Retain – this policy remains relevant.
H-185.932	Support for Inclusion of Vasectomy in the ACA Preventive	Our American Medical Association will work in concert with national specialty and state medical societies to advocate for patient	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
	Services and Contraceptive Mandate	access to the full continuum of evidence-based contraceptive methods and sterilization procedures, including vasectomy and male contraceptive counseling, to promote gender equity in contraceptive services under the ACA.	
H-190.955	Virtual Credit Card Payments	1. Our American Medical Association will educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via the Automated Clearing House. 2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards. 3. Our AMA supports transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion.	Retain – this policy remains relevant.
H-230.969	Strengthening Medical Staff Bylaws	The AMA: (1) will study the feasibility of assisting states in developing legislation to mandate that hospital medical staff bylaws be viewed as contracts; and (2) will study the feasibility of introducing federal legislation to mandate that medical staff bylaws be viewed as a contract.	Retain – this policy remains relevant.
H-275.955	Physician Licensure Legislation	Our AMA reaffirms earlier policy urging licensing jurisdictions to adopt laws and rules facilitating the movement of physicians between states, to move toward uniformity in requirements for the endorsement of licenses to practice medicine, and to base endorsement of medical licenses on an assessment of competence rather than on passing a written examination of cognitive knowledge.	Sunset this policy. This policy has been superseded by Policy H-275.978, as modified.
H-275.965	Health Care Quality Improvement Act of 1986 Amendments	The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists.	
H-280.950	Medicare's Three-Day Hospital Stay Requirement	Our AMA will ask the leadership of the American Association of Retired Persons, the Federation, the American Hospital Association, the Federation of American Hospitals, and the American Osteopathic Association to join with the AMA as signatories on a letter requesting that the Centers for Medicare & Medicaid rescind Medicare's three-day hospital stay requirement for access to skilled nursing care.	Sunset this policy. The HOD adopted more recent policy on this topic (i.e., H-280.947 "Three-Day Stay Rule"), and continues to advocate (e.g., sign-on letter) to the Centers for Medicare & Medicaid Services with other organizations.
H-280.977	Direct Admission of Medicare Patients to Skilled Nursing Facilities	Our AMA supports regulatory change and any necessary legislation which would delete the 3-day prior hospitalization requirement for provision of skilled nursing facility benefits under Medicare, so as to allow coverage for direct admission of Medicare patients to a skilled nursing facility whether or not they have been discharged from an acute care hospital within the last 30 days.	Retain – this policy remains relevant.
H-320.946	Radiology Benefits Manager	Our American Medical Association: (1) strongly encourages radiology benefits managers (RBMs) to adhere to uniform physician-developed best practice guidelines; (2) supports the use of appropriate use criteria developed by physicians with relevant expertise working in a collaborative process involving all national medical specialty societies that provide and/or order the imaging service in question; (3) supports an independent study assessing the magnitude of the cost and administrative burden of imaging utilization strategies on ordering physician offices, imaging providers, and patients and the impact these strategies have on patient safety and outcomes; (4) strongly encourages each radiology benefit manager (RBM) to publish and distribute the specific diagnostic codes used by their firm to approve or disapprove specific imaging procedures. This information should be distributed by the RBM via electronic or paper means to each physician who is credentialed to participate on health plans that utilize that particular RBM; and (5) opposes the practice of forced test substitution and arbitrary denial of requested imaging services by RBMs contracted by third-party payers that meet appropriate use criteria, and that RBMs be	Retain this policy in part. Clauses 1-5 of this policy remains relevant. The Physician Consortium for Performance Improvement referenced in clause 6 no longer exists, so this clause can be deleted.

Policy Number	Title	Text	Recommendation
		held accountable for harm caused by substitution or delay of requested studies~~;~~ ~~and (6) encourages the Physician Consortium for Performance Improvement? to continue to develop patient-centered measures, including those that address the appropriate use of imaging~~.	
H-330.897	Quality Cancer Care Preservation Act	Our AMA continues to support existing policy principles in evaluating legislative language on matters relating to Medicare reimbursement for physician acquisition and administration of prescription drugs.	Retain – this policy remains relevant.
H-330.928	Managed Medicare Reimbursement	The AMA advocates that Medicare managed care plans (e.g., Medicare Advantage, etc.) that use the RBRVS do so in a manner that maintains the relativity of the RBRVS utilized in the traditional Medicare program.	Retain – this policy remains relevant.
H-330.939	Reimbursement by Medicare for Psychotherapy Provided by Residents	The AMA will work with CMS to accomplish regulations for Medicare Part B payment for attending physicians' services that would not require the "physical presence" of the attending physician in the room at the same time that a resident provided psychotherapy.	Retain – this policy remains relevant.
H-340.903	Quality Improvement Organization Status	The AMA urges CMS to carefully review the potential for conflict of interest when the same organization that contracts as a Medicare Quality Improvement Organization fulfills similar quality improvement contracts in the private sector.	Retain – this policy remains relevant.
H-340.990	QIO Involvement in Quality Review and Physician Sanctions	The AMA urges modification of CMS's QIO contracts and regulations to provide that: (1) any perceived quality review assessment involving a member of a hospital's organized medical staff be concurrently presented for comment and review by the appropriate committee(s) of the organized medical staff; (2) the organized medical staff have the opportunity to make appropriate recommendations for corrections, when it deems that it is applicable, before the QIO shall act on a quality review matter; (3) the organized medical staff should act and inform the QIO organization in a reasonable period of time concerning what action, if any, was taken in relation to a perceived quality review problem; and (4) the QIO should be prohibited from taking any further action, such as sanctions of a member of the medical staff, before such medical staff involvement, review and reporting has been completed.	Retain – this policy remains relevant.
H-370.958	Removing Disincentives and Studying the Use of	1. Our AMA supports the efforts of the National Living Donor Assistance Center, Health Resources Services Administration,	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
	Incentives to Increase the National Organ Donor Pool	American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation. 2. Our AMA supports well-designed studies investigating the use of incentives, including valuable considerations, to increase living and deceased organ donation rates. 3. Our AMA will seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living and deceased organ donation.	
H-375.973	Protecting Physicians at the Peer Review Process in the Current Managed Care Environment	Our AMA: (1) will work with the Federation of State Medical Boards to adopt a policy to support state legislative efforts to protect the integrity and effectiveness of the peer review process by prohibiting managed care companies from automatically terminating providers who have been sanctioned by state medical boards or by information being provided by the National Practitioners Data Bank without providing due process to the provider; and (2) espouses as policy the guarantee of due process and civil rights safeguards to physicians in peer review and in credentialing.	Retain – this policy remains relevant.
H-375.990	Peer Review of the Performance of Hospital Medical Staff Physicians	Our American Medical Association encourages peer review of the performance of hospital medical staff physicians, which is objective and supervised by physicians. Membership on peer review committees and hearing panels should be open to all physicians on the medical staff and should not be restricted to those physicians who have an exclusive contract with the hospital, salaried physicians, or those on the faculty.	Retain – this policy remains relevant.
H-385.914	Stark Law and Physician Compensation	Our AMA opposes and continues to advocate against the misuse of the Stark Law and regulations to cap or control physician compensation.	Retain – this policy remains relevant.
H-385.941	Opposition to CMS User Fees	Our AMA strongly: (1) opposes any attempt on the part of the federal or state governments or other entities to impose user fees, provider taxes, access fees, or bed taxes on physicians and other health care providers to subsidize or fund any health care program; (2) opposes any directive from the CMS to slow down the rate of payment of Medicare claims or reduce administrative services to patients, physicians, and other health care providers; and (3) urges Congress to appropriate sufficient funds to enable the	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		CMS and its carriers to carry out their statutorily required functions.	
H-40.992	Prohibition of Pay Allowances to Military Physicians Serving in Managerial and Administrative Positions	The AMA opposes legislative or regulatory prohibition of the application of various special pay allowances to military physicians serving in executive and managerial positions.	Retain – this policy remains relevant.
H-405.989	Physicians and Surgeons	1. It is AMA policy to refer only to Doctors of Medicine (MDs) and Doctors of Osteopathy (DOs) as "physicians and surgeons." 2. The AMA supports working to ensure that federal and state regulations and hospital medical staff bylaws comply with this designation.	Retain – this policy remains relevant.
H-435.953	Minor Statute of Repose/Limitations	Our AMA supports federal legislation that would establish a Minor Statute of Repose/Limitations that includes the following language: An action by a minor upon a medical claim shall be commenced within 3 years from the date of the alleged manifestation of injury, except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides the longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.	Retain – this policy remains relevant.
H-435.956	Professional Liability Alternative Financing	Our AMA supports legislation that would amend the Internal Revenue Code to allow medical professionals and entities to establish tax-exempt professional liability trusts to pay medical liability claims.	Retain – this policy remains relevant.
H-435.969	Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability	Our AMA: (1) reaffirms its support for investigating promising Alternative Dispute Resolution (ADR) mechanisms, in the context of demonstration projects designed to evaluate whether they resolve medical liability claims fairly and in a more timely and cost-effective manner. (2) The AMA strongly recommends that if cost containment goals are to be achieved, ADR proposals designed to provide greater access to legal process must incorporate effective mechanisms to: (a) identify non-meritorious claims and dispose of them; (b) decrease the proportion of cases being litigated; (c) increase the portion of any settlement	Retain this policy in part. The reference to MICRA should be deleted. MICRA has been amended since this policy was first adopted and some states have stronger liability protections for physicians.

Policy Number	Title	Text	Recommendation
		payment received by the patient; and (d) identify appropriate guidelines for the payment of damages; and (3) continues to monitor and disseminate information to state and component medical societies about state and federal initiatives that address the issue of protections from liability risks for physicians who provide volunteer activities and care of the indigent, as well as the effectiveness of those initiatives. Effective medical liability reform~~, based on the California Medical Injury Compensation Reform Act (MICRA) model,~~ is integral to health system reform.	
H-435.975	~~Bush Administration Professional Liability Proposal~~ Federal Medical Liability Reform Policy	(1) Our AMA ~~commends the Bush Administration for its legislative efforts designated to achieve medical liability reform and~~ supports the elements of medical liability reform legislative proposals ~~introduced in the 102nd Congress~~ which are consistent with Association policy, including (1) limitations of $250,000 or lower on recovery of non-economic damages; (2) the mandatory offset of collateral sources of plaintiff compensation; (3) a decreasing, sliding scale regulation of attorney contingency fees; (4) periodic payment of future awards of damages; and (5) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than six years after birth. Effective medical liability reform~~, based on the California Medical Injury Compensation Reform Act (MICRA) model,~~ is integral to health system reform.	Retain this policy in part. The substance of this policy remains relevant; however, a new title and edits will more accurately describe this policy without tying it to a prior Congress or Administration. Also, the reference to MICRA should be deleted. MICRA has been amended since this policy was first adopted and some states have stronger liability protections for physicians.
H-435.983	Impact of Product Liability on the Development of New Medical Technologies	The AMA (1) urges the continuation of efforts at the state and federal level to reform product liability laws, (2) supports creative solutions to prevent product liability suits from slowing the development and utilization of medical technologies in this country. Effective medical liability reform~~, based on the California Medical Injury Compensation Reform Act (MICRA) model,~~ is integral to health system reform; and (3) continues to support efforts to alleviate the growing health crisis caused by decreasing availability or provision of biomaterials to manufacturers of medical devices and	Retain this policy in part. The reference to MICRA should be deleted. MICRA has been amended since this policy was first adopted and some states have stronger liability protections for physicians.

Policy Number	Title	Text	Recommendation
		implants and to support legislative efforts to provide legal protection to biomaterial suppliers to ensure that all Americans have access to medical devices.	
H-5.998	Public Funding of Abortion Services	Our American Medical Association reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.	Retain – this policy remains relevant.
H-95.937	Abuse-Deterrent Prescription Drugs	Our AMA supports the Food and Drug Administration's ongoing efforts to evaluate the efficacy, safety, and labeling of abuse-deterrent technology, and opposes barriers to appropriate access to and coverage of prescription drugs with abuse-deterrent properties.	Retain – this policy remains relevant.

10. AMERICAN MEDICAL ASSOCIATION CENTER FOR HEALTH EQUITY ANNUAL REPORT

Informational report; no reference committee hearing.

HOD ACTION: FILED

BACKGROUND

At the 2018 Annual Meeting, the House of Delegates (HOD) 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." This report marks the sixth AMA Health Equity report.

DISCUSSION

Our AMA has committed to advancing health equity, advocating for racial and social justice, and embedding equity across the organization and beyond. In 2024, 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 2024, 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 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 2024:

- At the 2024 Annual and Interim House of Delegates Meetings, equity-focused reports, resolutions, and education sessions were presented, including Council on Ethical and Judicial Affairs reports: "Short Term Global Health Clinical Encounters" and "Expanding Access to Palliative Care." The Council on Science and Public Health presented 18 reports on topics such as: Sex and Gender Differences in Medical Research, Universal Screening for Substance Use and Substance Use Disorders during Pregnancy, Stand Your Ground Laws, and Reducing Sodium Intake to Improve Public Health.
- The AMA Journal of Ethics published five equity-related issues such as Critical Pedagogies in Health Professions Education (Jan 2024); Global Medical Supply Chain Security (April 2024); Antimicrobial Stewardship (June 2024); Harm Reduction and Opioid Use Disorder (July 2024); and Sleep Stewardship (October 2024). The AMA released a podcast series, "Equity in our DNA: The Past and Promise of Genetics" in which experts discuss advances in modern medicine and provide insights into historical harms creating public mistrust. It provides an opportunity for viewers to understand how changes in precision medicine can reduce health equity gaps. Furthermore, the AMA, in collaboration with the U.S. Centers for Disease Control & Prevention (CDC), published seven episodes of the "Stories of Care" podcast series, resulting in 3,299 downloads and 1,405 continuing medical education completions. The AMA continued its campaign with the CDC and the Ad Council to promote flu vaccinations, focusing on Black and Hispanic/Latinx populations, reaching 1.6 million broadcast impressions and 404 million digital impressions.
- Diverse representation among AMA publications remained a goal. The AMA updated 29 images in the 2025 CPT Professional book to reflect diverse populations. Input was gathered from internal and external reviewers. This progress is contributing to AMA's four-year plan to update 75-100 CPT Professional book illustrations to depict authentic and diverse individuals.
- AMA content on health equity saw increased engagement in 2024, with 2.2 million website users, 23,200 referrals to the AMA Ed Hub, and 45 news articles. AMA expanded communication of equity initiatives through social media, newsletters including the Advocacy Update, Advocacy Insights webinar series, Center for Health Equity, CPT news email, and webinars. AMA social media had 343,000 views of health equity content with an average of one to two health equity related posts per week.
- On the AMA Ed Hub site, the AMA published 169 new equity-related activities and renewed 101, with engagements reaching 311,429 (vs. 189,721 in 2023) and completions increased to 68,700 (vs. 34,782 in 2023). The AMA partnered with medical schools to assign AMA health equity trainings, driving over 900 completions of health equity courses from medical student members. All four of the health equity foundational courses offered are in the top 15 percent of courses most utilized by medical students. Additionally, the AMA partnered with graduate medical education institutions to assign health equity courses to residents, resulting in more than 18,900 completions across more than 240 institutions. In 2024, there was an all-time high of foundations of health equity module completions seen in a year. Notably, in 2024, there were four newly uploaded quality improvement and patient safety (QIPS) courses and a new curriculum that centered on health equity focused patient scenarios. More than 4,000 resident members have enrolled in the curriculum since its launch in July 2024. Additionally, seven episodes of Prioritizing Equity were produced in 2024: Black Maternal Health; Voter Protections for During and After Incarceration; The Importance of Highlighting Historically Marginalized Physician's Journey Through Medicine; International Medical Graduates Experience in Medicine; Equitable Climate Action for Health; Culturally Responsive Communication Strategies for Equity; and Embedding Equity in Crisis Preparedness and Response in Health Systems Guide.
- The JAMA Network held quarterly diversity, equity, and inclusion (DEI) editor meetings to support DEI related concerns and share best practices. The JAMA fellowship welcomed eight early-career health equity scholars in the fully remote fellowship program, intended to foster accessibility and inclusivity of the program.
- In 2023-2024, the AMA evaluated external perceptions of its equity and social justice work and opportunities for strategic partnerships and allyships. There was a two-part analysis in support of these aims: a series of interviews with leaders within national equity and social justice organizations, and an analysis of social media conversations being had by the general public.

- Our AMA published playbooks and other educational resources for physicians, practices, and health systems, such as the health coaching toolkit to include the importance of community health workers, updated the Private Practice Playbook to include social determinants of health and health equity content, and developed virtual coaching options to help reach patients in traditionally remote and underserved communities. STEPS Forward® has continued to hold events, reaching a wider audience of attendees, while maintaining discounted attendance for federally qualified health centers (FQHCs) and safety-net providers. The bootcamps offer evidence-based time management and team-based care strategies to provide quality patient care. The Private Practice Simple Solutions learning collaboratives were created in support of practices in communities that may lack financial resources to engage with consultants or other external partners and continued to run through 2024, expanding to timely and relevant topics that are often complex in nature and that these practices may need support on, such as the implementation of virtual assistants or value-based care.

The AMA's employee life cycle and internal DEI framework helped 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:

- Our AMA supports DEI initiatives through nine Employee Resource Groups (ERGs), fostering inclusion and belonging across the organization. In 2024, the ERGs collectively had 640 staff who were members of their groups and hosted over 90 events designed to advance equity learning, cultivate community, and support the personal and professional development of their members.
- Staff are strongly encouraged to seek equity-focused learning opportunities, with minimum hours set in the organization's first year of internal enterprise-wide equity goals, and staff averaging over 16 hours in 2024. Among business units (BUs), staff have organized educational activities and events to strengthen community engagement and learning. As an example, AMA Insurance (AMAI) organically produced and presented a six-hour long Lunch and Learn training focused on equity and inclusion. Each AMAI staff is responsible for logging their required minimum of 7.5 hours of equity training/related programming participation.
- In addition, the Center for Health Equity and Human Resources have offered equity focused workshops to support staff completion of their equity learning goal. Staff participated in the Racial Equity Trainings offered by the Racial Equity Institute, the Diversity, Equity, Inclusion, and Belonging Foundation Course through Be More with Anu, and skill-based inclusion modules on Psychological Safety, Inclusive Communication, Identifying and Responding to Microaggressions, and Inclusive Facilitation. For the skills-based modules, 246 staff members completed 362 workshops, reflecting both a 36 percent increase in staff participation and a 41 percent increase in the number of completed workshops when compared to 2023. These trainings provided and/or helped refine actionable skills to promote inclusion across the employee lifecycle at the AMA.
- The AMA offered the staff management team, in partnership with Equity & Results, an in-person and virtual live workshop series on Antiracist Results-Based Accountability. Participants learned root cause analysis for inequities, strategy development to address "hot roots" and "pain points" that drive inequity, and operational plan and performance measurement development to enhance equitable impact internally and externally. A seven-session series (final four sessions in 2024) included 47 unique equity leads (including current and former business unit equity action team members) across all 18 BUs and one affiliate with 82 percent of the final session's survey respondents agreeing or strongly agreeing to knowledge gained. A three-session series, in support of enterprise-wide equity goals, included 57 directors and vice presidents from all business units, with more than half agreeing or strongly agreeing they were confident about applying what they learned.
- Our AMA continues to work toward identifying and replacing offensive terminology across the enterprise. The AMA conducted a comprehensive search for outdated terms in our information technology (IT) systems and has embarked on instituting these updates starting in 2025 to replace harmful language.

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 2024:

- Our AMA launched the second iteration of the AMA's Strategic Plan to Embed Racial Justice and Advance Health Equity to advance health equity, with a viewpoint summarizing AMA's renewed commitment to the work and lessons learned from the original strategic plan.
- The AMA continued the Summer Health Law Internship and will continue in 2025, expanding from an eight-week to a ten-week paid summer internship for a rising third-year law student, with a focus on health disparities and the law.
- The AMA's Release the Pressure campaign, alongside the Henry Schein Cares Foundation, American Dental Association, National Medical Association, Care Quest Institute for Oral Health, and the Arnold Gold Foundation created the Prevention is Power Coalition. Educational materials including fact sheets, posters, and patient cards on hypertension for Federally Qualified Health Centers were created and reached over 800 organizational members and 65,000 health-focused followers through the National Association of Community Health Center's network.
- The AMA conducted a survey to understand physician perceptions of their health center-built environments and assess impact on their well-being. Of the 12,277 contacted, 526 responded and 281 agreed to follow-up interviews. The surveyed physicians included American Indian or Alaskan Native/Native Hawaiian or Pacific Islander, Hispanic or Latino, Black or African American, Middle Eastern or North African. The surveyed physicians are in the process of being connected with diverse learning communities such as Rise to Health and In Full Health resources.
- Seven new partners joined the AMA's Ed Hub in 2024, including Institute for Healthcare Improvement, Johns Hopkins University, National Association of County and City Health Officials, National Resources Defense Council, Oregon Health & Science University, OutCare Health, and The Permanente Medical Group. These organizations will be contributing to equity-related content on AMA Ed Hub site.
- Out AMA continued to follow the Enterprise Social Responsibility (ESR) team's health equity framework to build meaningful relationships with community organizations. In 2024, the ESR team hosted over 40 community engagement events with organizations including Erie Neighborhood House, Gardeneers, Nourishing Hope, Pilsen Food Pantry, and Project Linus. To highlight, AMA's ESR team partnered with MyBlock MyHood MyCity to co-design a weeklong service event. The weeklong service event celebrated the AMA ESR program's fifth year anniversary and provided volunteers with deeper engagement to build upon health equity work that is already happening in the community. The weeklong event impacted 423 residential homes and 12 neighborhood blocks.
- Additionally, there are increased efforts to contract with minority- and/or women-owned or led businesses for AMA projects, including local West Side vendors, which has led to successful agreements. The AMA continues to participate in monthly West Side United (WSU) Anchor Partner meetings and attended a vendor summit event, meeting several WSU vendors in person.
- Our AMA's 2024 media sponsorships focused on reaching diverse audiences, supporting events with the National LGBTQ+ Journalists Association, the Asian American Journalists Association, and the National Association of Black Journalists, to name a few.
- In collaboration with the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, the AMA released recommended standards for collecting, reporting, and sharing race, ethnicity, and language data in health care. The standards represent a multi-year initiative around sociodemographic physician workforce data. Organizations, such as MedBiquitous, have agreed to adopt and promote these standards to the health care community.
- In 2024, our AMA continued collaborative research that leverages critical data from the AMA's Physician Professional Data aimed to study and evaluate the most pressing issues impacting equitable care.
- AMA has a goal to scale solutions to improve blood pressure control for five million patients diagnosed with hypertension (HTN) with a specific goal to impact one million patients identified as Black, Latina/e/o/x/Hispanic, Asian, Indigenous, and other historically marginalized groups. At the end of Q4 2024, approximately 2,589,155 patients were reached, and have impacted 774,261 patients with hypertension towards the goal of five million, with 38 percent from historically marginalized populations. AMA is embedding and advancing equity within its AMA MAP HTN™ program by evaluating program data, developing tools for health care professionals to identify inequities in blood pressure control rates, and

creating inclusive patient education materials related to cardiovascular disease prevention that have been translated into over 15 languages.

- Across the enterprise, individual BUs sought out ways to embed equity within their departments. As an example, the AMA continued hosting students from historically marginalized backgrounds with the opportunity to visit the AMA, engage with AMA IT professionals, and learn about the organization's history and its role in promoting national health and wellbeing. Similarly, JAMA partnered with the Urban Alliance on a summer internship program to provide opportunities for Chicago students to explore Medical Editing and Publishing as a career path.
- The AMA contributed to revising the Declaration of Helsinki, supporting the creation of the new version that more effectively addresses health determinants and inequity. For example, the revision has a stronger emphasis on environmental considerations, for the first time requires post-clinical trial provisions (such as providing any intervention identified as beneficial and reasonably safe in the trial for participants who still need it) and discusses vulnerability in a more nuanced way.
- The AMA continued to partner with March of Dimes and Sinai Urban Health Institute to examine the impact of facility closures and loss of services on the South and West Sides of Chicago, publishing a final report in August 2024, titled "From Facilities to Outcomes: A Neighborhood-Level Examination of Maternal and Infant Care Access in Chicago."
- Our AMA conducted 32 burnout assessments at FQHCs and/or community health centers, all organizations serving patients from predominantly historically marginalized communities, including 23 organizations in the Arizona Alliance, a consortium of FQHCs. Several virtual workshops and reporting sessions to provide insight into interventions to reduce medical staff burnout were held.
- Several participating FQHCs were recognized through the AMA's Joy in Medicine™ Health System Recognition Program. AMA continued to work with FQHCs, and staff traveled to an FQHC located in Chicago's South Side, Alivio, and met with their leadership team to learn more about their needs and challenges.
- AMA staff continue to be present at minoritized and marginalized physician convenings to grow and foster relationships, as well as learn about health care priorities of these groups. Staff participated in various conferences to support building alliances, learning about the context necessary for restorative practice, and incorporating context into the AMA's own work. These conferences included: 8th Annual Urban Native Education Conference, National Hispanic Medical Association 30th Anniversary Celebration and Leadership Summit, Unidos US Annual Conference, Access in Medicine Summit, National Medical Association National Colloquium on African American Health and Annual Convention and Scientific Assembly, The Latino Medical Student Association National Conference, American Association of American Indian Physicians 52nd Annual Meeting and Health Conference, GLMA's 42nd Annual Conference on LGBTQ+ Health, and AAMC Annual Meeting. Staff gained insights into incorporating restorative practices and equity into AMA's work.

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 2024:

- 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 2024, the AMA continued to actively voice support for:
    - International medical graduates;
    - Deferred Action for Childhood Arrivals recipients;
    - Migration and refugee population health and safety;
    - Nutrition programs expansion and culturally respectful dietary guidelines;
    - Medicaid coverage expansion;
    - Medicaid and Children's Health Insurance Program coverage extension;

  - Maternal and child health programs;
  - Protecting reproductive health;
  - Advancing data privacy principles and protecting the abuse/misuse of sensitive health data;
  - Enhanced revisions to the federal race and ethnicity data standards;
  - Mental health and substance use disorder parity laws;
  - Protections for physicians who seek care for wellness and burnout;
  - Evidence-based gender affirming care;
  - Prohibition of the so-called conversion therapy;
  - Fair student loan efforts;
  - Increased funding for graduate medical education;
  - Elimination of harmful race-based clinical algorithms;
  - Telehealth flexibilities in Medicare;
  - Reducing the prior authorization burden on patients; and
  - Addressing quality and administrative barriers in Medicare Advantage and other insurance plans.
- The AMA amplifies voices of historically marginalized individuals through its litigation efforts. Examples from this past year:
  - Reproductive health and gender-affirming care: The AMA has filed and joined dozens of amicus briefs across the country on these critical issues in state and federal courts, including several briefs at the U.S. Supreme Court. The briefs have consistently emphasized the harm that government interference in the patient-physician relationship has on marginalized communities. The litigation team has also provided support to the AMA's Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted.
  - Anti-smoking: The AMA has continued to be a central voice in litigation on anti-smoking efforts, including serving as a named plaintiff in a case to ban the sale of menthol cigarettes. The AMA has also joined several amicus briefs supporting state and local restrictions on flavored tobacco and briefs supporting restrictions on flavored electronic nicotine delivery systems, including in the U.S. Supreme Court.
  - Affordable Care Act (ACA) Preventive Care: The AMA has been a leader in organizing amicus briefs supporting the ACA and opposing efforts to dismantle the preventive care provisions of the law. These briefs have included dozens of Federation members and have been filed at all levels of the case.
  - Medicare: The AMA has supported the federal government's efforts to support health equity in Medicare through the use of anti-racism plans under the MIPS program.
  - Internal and External Communication: The litigation team routinely communicates with state and specialty societies about possible collaboration efforts in order to support health equity in the courts.
- The AMA proposed revisions adopted into World Medical Association policy, advocating against anti-LGBTQ+ legislation worldwide. AMA also supported and facilitated World Medical Association policies addressing humanitarian issues in Gaza and Turkey. Additionally, the AMA facilitated an opportunity for Jesse Ehrenfeld, MD, MPH, to speak and participate in a panel at the World Medical Association General Assembly on the opportunities and risks of innovation in health equity.
- The AMA hosted the first two hybrid National Health Equity Grand Rounds: Advancing Health Equity Through Resistance: A State of the Union on Threats and Opportunities in New York City, with 990 live attendees, and Rewrite the Script: Narrative Transformation for Equity in Health at the Facing Race conference in St. Louis, Missouri, with 1,044 live attendees. Overall, 90 percent of Grand Rounds viewers reported that they were satisfied or very satisfied with the 2024 events.
- In its second year, the Health Equity in Organized Medicine (HEIOM) survey was distributed to the AMA Federation of Medicine in January 2024. The survey seeks to understand the current state of organized medicine’s efforts in advancing health equity and developing a shared understanding of equity initiatives across states and specialties. Despite an increasingly complex political landscape and efforts to discredit diversity, equity, and inclusion initiatives, the 2024 HEIOM survey found continued engagement around equity and inclusion efforts across various sectors. Notably, 74.1 percent of organizations reported taking at least one action to make equity a strategic priority. Among organizations that completed both 2023 to 2024

surveys, 51.9 percent reported completing or sustaining the majority of their actions, and no organization reported stopping or canceling the effort they had underway in 2023.

- In response to AMA HOD policy D-405.970: Racism – A Threat to Public Health, the AMA submitted new ICD-10 codes focused on the conditions related to the experience of racism to the National Center for Health Statistics in 2024. The AMA supported the successful implementation of Gravity Project's social determinants of health terminology and Fast Healthcare Interoperability Resources exchange standards across the state of New York (NY) to provide the data standards necessary to more effectively identify and address the health-related social needs of 6.9 million Medicaid beneficiaries. The use of these standards in NY, and across the country, also enables the stories of marginalized populations to be more accurately told in a way that was not possible before the Gravity Project. When aggregated, this data will help local, state, and federal officials to make more informed decisions about the needs of these marginalized populations and the impact of addressing these needs on health care outcomes and spending.
- The AMA has worked to close coverage gaps in Medicaid programs so that beneficiaries have coverage for a blood pressure (BP) monitoring device and cuff. AMA has also worked to increase Medicaid coverage for clinical services related to self-measured blood pressure.
- In Atlanta, the AMA collaborated with the CDC, local American Heart Association (AHA) representatives, and a local collaborative on health improvement to convene more than 75 organizations and align solutions to social drivers of health to improve blood pressure for Black adults. Notably in Atlanta, the Medical Association of Georgia and Medical Association of Atlanta are engaging their membership locally. The AMA has deployed AMA MAP™ resources, tools, and educational content to health care organizations in the Atlanta area.
- New STEPS Forward® content helped address determinants of health and inequities. For example, 2024 STEPS Forward® podcast content included episodes focused on (1) Integrating a Community Health Worker into Team-based Care, (2) Connecting the Dots Between Social Determinants of Health and Climate Change, (3) Frontline Connect: Eliminating Barriers to Mental Health Services for the Health Care Workforce, and (4) I felt such a shame to be me: How One Medical Educator is Working to End Mental Health Stigma in Medicine.
- As part of The AMA Foundation's Health Equity Accelerator fund, the AMA was awarded a two-year $2.3 million collaborative grant to focus on promoting equitable practices and diversity in the admissions process after the 2023 U.S. Supreme Court (SCOTUS) decision on affirmative action. The proposal was written to supplement ongoing efforts, including a separate set of roundtable discussions, the completion of the book *Remaining Medical Education: The Future of Health Equity and Racial Justice*, and broader Medical Education strategies. The grant-funded initiative, referred to as Equity and Justice in Medical Education, is convening key stakeholders most affected by the SCOTUS decision to collect their reflections on the challenges and opportunities of the changing landscape. The participating organizations include the National Medical Association, National Hispanic Medical Association, Association of American Indian Physicians, National Council of Asian Pacific Islander Physicians, Asian Pacific American Medical Student Association, Latino Medical Student Association, Association of Native American Medical Students, Student National Medical Association, American Association of College of Osteopathic Medicine, and the Association of American Medical Colleges. A total of six convenings will be held during the grant period. These convenings aim to foster collaboration between participants with the hope of developing common approaches that will leverage collective influence while not countermanding efforts of any one organization over another.

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 2024:

- The new Health Solutions Innovation Framework now includes Equity Impact as a mandated quadrant of the Product Lean Canvas (a one-page business plan to help determine if a product is worth moving forward) and continues to propagate across the additional stages through product development and delivery.
- The AMA hosted an expert convening on postpartum HTN to identify best practices for postpartum blood pressure monitoring and management. Specifically, convening participants highlighted that policy change,

further research, and practice tools and resources are needed to support broad improvements in postpartum HTN care.

- The AMA worked with external organizations, health innovation and technology companies to encourage organizations that support health care delivery, such as health technology, payers, and others, to use an equity lens to understand population representation within their studies and programs, investment and removal of barriers for those who have been historically marginalized, and transparency for specific populations. Additionally, the US Validated Blood Pressure Device Listing has continued to grow in number and variety of devices, including broader cuff sizes and lower price points to reach a broader population in need.
- The AMA continued to strive toward the adoption, optimization, and sustainability of responsible, impactful and equitable digitally enabled innovations. This included highlighting organizations that are championing and implementing health equity via the Physician Innovation Network (PIN) and providing a place through PIN to engage in important conversations centering the Principles of Equitable Innovation. The AMA connected stakeholders and fostered collaboration to improve the development, evidence base, and quality of digital health solutions.
- The AMA provided Innovation Grants to twelve organizations and developed a community of practice where grantees meet monthly. As part of the AMA "Innovation in Medical Education Series" with Elsevier, the recently published *Reimagining Medical Education: The Future of Health Equity and Social Justice* illuminates multiple aspects and points of view connected to this important and evolving topic. This externally commissioned publication was written in response to a 2021 report by the AMA Council on Medical Education. The AMA Council on Medical Education report included a directive to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce and ameliorating inequitable outcomes among minoritized and marginalized patient populations. The book was published in November 2024 after an extensive process of selecting an editorial panel and facilitating dialogs on developing a common vision for the book. The book envisions medical education's many concrete and potential contributions to social justice and racial equity. The AMA contracted with the Social Mission Alliance to review the book and identify their recommendations of which parts of the book may be most important and feasible to enact quickly. A report with those recommendations was submitted in October 2024 and it will be used with other analyses to help build a strategy on enacting recommendations from the book.

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 2024:

- Presented the restorative justice framework and community engagement plan for conversation at the Association of American Indian Physician's 52nd Annual Meeting and Health Conference, entitled "A Pathway and Journey Toward Truth and Reconciliation;" at the GLMA Health Professionals Advancing LGBTQ+ Equity (GLMA) 42nd Annual Conference on LGBTQ+ Health in a Lunch Plenary and Discussion on Restorative Justice and Representation; and at the GLMA Workshop, "Restorative Justice in Medicine Workshop."
- A cross-enterprise, cross-functional staff team has been supporting the Truth, Reconciliation, Healing and Transformation (TRHT) Task Force that was established by HOD policy.
    - Facilitated, supported and worked closely with two TRHT Task Force sub-groups (Writing and Narrative), including creation of recommendations and guidance to plan collection of testimonies from physicians, advocates and patient populations on historical harms in medicine, and implementation of the plan to collect physician narratives for the report to the Board.
    - Planned and implemented educational opportunities for TRHT task force members, staff, and minoritized physician groups including three asynchronous learnings in October on the History of Medical Harms in the Asian and Pacific Islander American community (Winston Wong, MD, MS),

The AMA and Harms Arising from Exclusionary Training (Harriet Washington, MA) and Research on Race and Health in the US: Some Historical Background (David R. Williams, PhD, MPH, MA).
    - Planned and supported the TRHT Task Force Meeting with two panel presentations: (1) The Legacy of Medical Experimentation and Maternal Health featuring Michelle Browder and Lee Sharma, MD and (2) Developing Responsive Policies and Practices to Maternal and Reproductive Health Inequities in the Region featuring Tom Ellison, MD, PhD; Natalie Hernandez, PhD, MPH; and Yolanda Lawson, MD.
- The AMA partnered with the Institutional Antiracism and Accountability (IARA) Project, funded by a Robert Wood Johnson Foundation grant, subgranted by the AMA Foundation. IARA's Truth, Reconciliation, Healing, and Transformation Archival Research Project is using their specially granted access to AMA archival materials to examine the historical roots of health inequities in the U.S. and will use this work to inform actionable strategies for advancing health equity.
- The AMA continues its work of revising the AMA Guides to the Evaluation of Permanent Impairment, in accordance with existing AMA policy on race as a social construct and national standards of care, to modify recommendations that perpetuate racial essentialism or race-based medicine. Specifically, a race-neutral approach to pulmonary function test interpretation algorithms is being implemented by reporting and interpreting results using average reference equations rather than using race-based calculations.
- The AMA and Association of American Medical Colleges (AAMC) were invited by one of the partners of The REParations and Anti-Institutional Racism (REPAIR) Project to co-sponsor an event for May 2024 on their campus. The REPAIR Project is a three-year initiative designed to address anti-racism and better incorporate structural competency in science and medicine. The project recognizes that long-standing racial inequities in health, health care institutions and scholarship are a result of systemic race-based violence and racism in society as a whole and seeks to open conversation and promote efforts to rectify and eliminate these problems. It also recognizes the need to support a strategy of maximizing the effect of the Liaison Committee on Medical Education standard on structural competency to accelerate health equity.

Challenges & Opportunities

Across the AMA, several challenges have been identified in advancing health equity goals. Time constraints and the lack of prioritization for equity-focused projects amid competing demands remain significant hurdles. Smaller teams struggle to allocate time for participation in events and for equity action team meetings. Additionally, some BUs report limited access to subject matter experts, further complicating efforts to develop equitable internal strategies.

A recurring challenge is ensuring leadership elevates marginalized perspectives, staff, collaborators, contractors, and patients and communities most impacted by inequities. The same individuals have often been driving equity initiatives for years, leading to fatigue within equity action teams. Equity-related work often takes a backseat to other organizational priorities, leaving staff feeling overwhelmed by the magnitude of inequities and the limited time to address them. There is difficulty in embedding equity into team practices in places where direct leadership support and involvement is less robust.

The cross-enterprise antiracist results-based accountability training course has provided an opportunity for equity champions and leadership to identify opportunities and strategies to embed equitable principles throughout AMA systems and structures. However, there remain varying levels of understanding of root causes of inequities and confidence in applying equity strategies among staff and varying degrees of commitment to integrating equitable approaches (e.g., data transparency, inclusive decision-making) among leadership.

CONCLUSION

This report highlights only a portion of the work accomplished and lessons learned in 2024. AMA staff have devoted countless hours to learning how they can collaborate in advancing health equity and applying those insights within and beyond the organization. The AMA remains committed to driving progress toward health equity and embedding racial and social justice, making meaningful progress toward fulfilling the commitments outlined in both iterations of the Strategic Plan.

11. AMA EFFORTS ON MEDICARE PAYMENT REFORM

Informational report; no reference committee hearing.

HOD ACTION: FILED

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 a predictable, sustainable, fair physician payment system 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 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; 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

The AMA shares its members' deep frustration over the persistent cuts to Medicare payments. While Congress mitigated approximately half of the 2024 Medicare physician payment cuts that were initially implemented in January 2024, physicians continue to sound the alarm about how two decades of annual cuts are jeopardizing practice viability and limiting patient access to care. Unfortunately, the final 2025 Physician Payment Rule imposed an additional 2.83 percent cut.

An early draft of a year-end legislative package in December included a proposal to address 2.5 percent of the scheduled cut. However, this proposal collapsed under political pressure, and the scaled-down spending package that ultimately passed failed to address the payment cuts. As a result, physicians are now facing Medicare cuts for the fifth

consecutive year, which went into effect on January 1, 2025. Meanwhile, CMS projects that the MEI will increase by 3.5 percent in 2025, further widening the gap between what Medicare pays physicians and the actual cost of delivering quality patient care.

The financial stability of physician practices and the long-term sustainability of the nation's entire health care system are at serious risk. Medicare physician payment rates have effectively plummeted 33 percent from 2001 to 2025 when adjusted for inflation in practice costs. Addressing this widening gap is essential to ensure physicians can continue providing high-quality care to Medicare patients.

Fixing our unsustainable Medicare payment system will remain an urgent advocacy and legislative priority for our AMA until meaningful reform is achieved. The need to stop the annual cycle of pay cuts and patches and enact permanent Medicare payment reforms could not be clearer. Because of Congress' failure to reverse these cuts, millions of seniors will find it more difficult to access high quality care and physicians will find it more difficult to accept new Medicare patients. The impact of sustained, year-over-year Medicare payment cuts will become noticeable first in rural and underserved areas and with small, independent physician practices which will be highly detrimental for some of our nation's most vulnerable patients.

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 were circulated and commonsense legislation introduced to address the broken Medicare physician payment system and build upon "Characteristics of a Rational Medicare Physician Payment System" including:

Medicare Reform: Automatic Annual Inflation-based Updates

- The AMA and our Federation partners continue to advocate for an inflation update to Medicare payments, on top of reversing the new round of 2.83 percent cuts that began on January 1.
- The 118th Congress took an important first step toward Medicare reform with the introduction of H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," a bill that would provide automatic, annual payment updates to account for practice cost inflation as reflected in the MEI. We will advocate for the introduction of similar legislation in 2025.
- Tying annual payment updates to the MEI has long been supported by the AMA to promote the financial viability of physician practices and place physicians on equal ground with other health care providers. Federation groups have joined forces in seeking bipartisan cosponsors for this legislation and to educate Congress on why it is needed.

Medicare Payment Reform: Budget Neutrality

- A bill that was strongly supported by the AMA was introduced in the House last year by the co-chairs of the GOP Doctors Caucus (H.R. 6371), based on AMA recommendations, that would reform the budget neutrality policies that have been producing across-the-board payment cuts. The bill would have:
  - Required CMS to review actual claims data and correct flawed utilization projections that cause inappropriate conversation factor cuts or increases; and
  - Raised the spending threshold that triggers a budget neutrality adjustment from $20 million to $53 million.
- The AMA is advocating for the introduction of similar legislation in 2025.

Medicare Payment Reform: Revising the Medicare Merit-based Incentive Payment System (MIPS)

- Together with Federation groups, the AMA has developed legislative language to improve the MIPS program. The AMA draft would:
  - Address steep penalties that are distributed unevenly and disproportionately impact small, rural, and independent practices;
  - Hold CMS accountable for providing physicians with timely and actionable data; and
  - Reform MIPS so that it is more clinically relevant and less burdensome.
- We will work to advance these MIPS reforms with the new Administration and Congress.

Summary of Recent AMA Advocacy Efforts at the end of the 118th Congress and beginning of the 119th

- On September 10, the AMA joined more than 120 organizations representing more than one million health care providers and their patients in a sign-on letter calling on Congress to take action to address the unsustainable Medicare physician payment system. The letter specifically mentioned three pieces of bipartisan legislation that were introduced in the 118th Congress to address systemic flaws to the Medicare physician payment system, all of which the AMA has advocated in support of:
    - The Strengthening Medicare for Patients and Providers Act (H.R. 2474) which would enact an annual, permanent inflationary payment update in Medicare that is tied to the MEI;
    - The Physician Fee Stabilization Act (S. 4935), which would increase the budget neutrality threshold under the Medicare physician Fee Schedule and provide regular indexing to the MEI; and
    - The Provider Reimbursement Stability Act (H.R. 6371), which would build upon the provisions in S. 4935 through its inclusion of additional key components to reform budget neutrality laws.

- In October, Representatives Mariannette Miller-Meeks, MD (R-IA) and Jimmy Panetta (D-CA), along with 233 bipartisan members of Congress sent a "Dear Colleague" letter urging House leadership to take immediate action to not only stop the 2.8 percent cut, but also provide physicians with a much-needed payment update that reflects the inflationary pressure they are facing running a medical practice.

- As a direct result of AMA advocacy efforts, Reps. Greg Murphy (R-NC), and Jimmy Panetta, (D-CA) introduced in October, H.R. 10073, the "Medicare Patient Access and Practice Stabilization Act of 2024" to eliminate the 2.83 percent Medicare cuts and provide physicians with a 1.8 percent payment increase.

- On November 15, an AMA-led letter co-signed by 128 national medical societies and state medical associations was sent in support of Congress expeditiously passing H.R. 10073 before January 1, 2025.

- On November 21, a bipartisan, Senate "Dear Colleague" letter led by Sens. John Boozman, (R-AR) and Peter Welch, (D-VT) with 41 signors was sent to Senate leadership warning the cuts would interfere with the ability of physicians to provide high-quality care supporting efforts to prevent a pending 2.8 percent cut in Medicare physician payments that went into effect on January 1.

- As a result of AMA advocacy efforts, Reps. Greg Murphy, MD (R-NC) and Jimmy Panetta (D-CA), along with a bipartisan group of legislators, introduced in January the Medicare Patient Access and Practice Stabilization Act of 2025 (H.R. 879). This legislation, with more than 120 co-sponsors, would prospectively cancel the 2.83 percent payment cut that went into effect on January 1, while also providing a 2.0 percent payment update, helping to stabilize physician practices and protect patients' access to care.

- In February, an AMA-led sign-on letter was sent to Congressional leadership with 80 medical specialty societies and all 50 state medical societies urging Congress to reverse the 2.83 percent Medicare payment cuts and provide physicians with a meaningful payment increase that reflects ongoing inflationary pressures and to pass H.R. 879, the Medicare Patient Access and Practice Stabilization Act.

- In March, the AMA signed onto a letter with several other physician groups to Congressional leadership calling on Congress to include H.R. 879 in the March continuing resolution appropriations legislation. Unfortunately, H.R. 879 or provisions reversing the 2.83 Medicare cuts were not included in the March appropriations legislation.

Physician Call to Take Action

The AMA will continue to work with Congress to build bipartisan support 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.

AMA National Advocacy Conference - February 2025, Washington, DC

The Advocacy team successfully hosted several members of Congress during the AMA National Advocacy Conference (NAC) at the "Fix Medicare Now" Kick Off event, held at the Cannon House Office Building. Notable attendees included Reps. Greg Murphy, MD (R-NC), Jimmy Panetta,
(D-CA), Kimberly Schrier, MD (D-WA), Mariannette Miller-Meeks, MD (R-IA), John Joyce, MD (R-PA), Raul Ruiz, MD (D-CA), Ami Bera, MD (D-CA), and Mike Kennedy, MD (R-UT). These legislators addressed the physician attendees and voiced their support for H.R. 879, emphasizing the urgent need to reverse Medicare payment cuts to protect patient access to care and stabilize physician practices.

The "Fix Medicare Now" Kick Off event was a powerful visual statement of physician unity against the payment cuts, with hundreds of physicians dressed in white coats rallying together. Physicians participated in over 350 visits with House members and senators, urging them to support H.R. 879 and introduce companion legislation in the Senate.

Additionally, physicians at the NAC were equipped with an AMA action kit that focused solely on Medicare physician payment, including compelling facts and figures demonstrating the adverse effects of the Medicare payment cuts, including the statistic that physicians are now being paid 33 percent less for Medicare services (adjusted for inflation) than they were in 2001.

The AMA also took out a full-page advertisement in The Hill, advocating for passage of H.R. 879. The ad included a QR code directing viewers to more information about the legislation.

The AMA NAC further featured presentations by several congressional members at the Grand Hyatt, including Herb Conaway, MD (D-NJ), Robert Onder, MD (R-MO), Raja Krishnamoorthi, (D-IL), Maxine Dexter, MD (D-OR), Kelly Morrison, MD (D-MN), Diana DeGette, (D-CO), and Rich McCormick, MD (R-GA). All these Members expressed the need to stop the Medicare cuts and to reform the payment system.

Our AMA President opened the conference by highlighting the unsustainable financial pressures physicians face and the urgent need to fix the broken Medicare payment system.

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

To support the Medicare legislation cited above, the AMA has been engaged in a major grassroots campaign to engage patients and physicians in our lobbying efforts. The following 2025 statistics result from the Fix Medicare Now campaign and engagement with the Physician Grassroots Network and Patients Action Network.

- 50+ million in earned media and ad impressions,
- 2 million+ media and ad engagements,
- 292,000+ pageviews,
- 276,000+ site users,
- 52,000+ contacts to Congress, and
- A combined 150+ third-party media placements and grass top contacts made in key Congressional districts.

Continuing Advocacy Amidst Legislative Challenges

We do not expect quick action in Congress in the near term to advance legislation to reform the Medicare physician payment system and include permanent MEI payment updates given its potential to cost more than $300 billion over a 10-year period. The Republican majority in the House and Senate is currently focused primarily on adopting a final budget resolution that would allow for "reconciliation" legislation to extend expiring tax cuts and significantly reduce federal spending while bypassing Senate filibuster rules. Achieving consensus on tax, spending, and budgetary matters has always been very challenging in Congress.

Despite these hurdles, the AMA advocacy team has made substantial progress in laying the groundwork for Medicare physician payment reform. This report has highlighted the team's efforts, including:

- Aggressively advocating to replace the 2.83 percent Medicare physician payment cut that took effect on January 1, 2025, with a payment update that better reflects practice costs;
- Pushing for reforms to the budget neutrality process, the MIPS program, and modifications to APMs;
- Strengthening coalitions by partnering with allied professions and the patient community, both of whom are negatively impacted by the broken Medicare payment system;
- Organizing grassroots efforts and ensuring continuous physician engagement through initiatives like the Physicians Grassroots Network; and
- Equipping physicians with advocacy tools and resources to effectively communicate their concerns and solutions to lawmakers.

The journey toward comprehensive Medicare physician payment reform will not be easy, but the AMA remains unwavering in its commitment to this cause. By building on each incremental reform, the AMA is establishing a strong foundation for eventual success.

As physicians across the country continue to share their stories and advocate for reform, there is hope that our united efforts will eventually break through the political and financial barriers that have hindered progress. The AMA will continue to fight tirelessly until a sustainable, fair, and effective Medicare physician payment system is achieved.

CONCLUSION

The AMA will continue to engage the federation and press Congress to develop long-term solutions to the systematic problems with the Medicare physician payment system and preserve patient access to quality care. Despite the aforementioned challenges, the continued engagement of the physician community is crucial. It is vital to continue advocating for reform, engaging with legislators, and highlighting the real-world impacts of the current, broken system on patient care and physician practices. Please follow Advocacy Update, join the Physicians Grassroots Network, visit www.FixMedicareNow often for updated material and alerts, and follow other AMA communications vehicles to stay up to date and engaged on this topic.

12. TASK FORCE TO PRESERVE THE PATIENT-PHYSICIAN RELATIONSHIP WHEN EVIDENCE-BASED, APPROPRIATE CARE IS BANNED OR RESTRICTED

Informational report; no reference committee hearing.

HOD ACTION: FILED

This report provides an update on the activities of the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted (Task Force) in accordance with Policies G-605.009, D-5.998, and D-605.982. (Note: Because of approval deadlines, this report was prepared in February and may not include more recent developments.)

BACKGROUND

American Medical Association (AMA) Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted," was adopted at the 2022 Annual Meeting of the AMA House of Delegates (HOD). Policy G-605.009 instructs that:

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
    a. 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;
    b. 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;
    c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
    d. 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;
    e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
    f. 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; and
    g. 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.

Adopted during the AMA 2022 Interim Meeting, Policy D-5.998, "Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era," added a requirement for an annual report of the Task Force. Policy D-5.998(1) instructs that:

1. Our AMA Task Force developed under HOD Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted," will publish a report with annual updates with 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.

At the AMA 2023 Interim Meeting, the HOD amended Policy G-605.009, adding the creation of an ad hoc committee on payment and reimbursement issues in gender affirming care to the Task Force's directives. Specifically, the amendment instructs that:

1. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care.

At the AMA 2024 Interim Meeting, the HOD amended Policy G-605.009, adding that the Task Force:

h. Work with interested parties to encourage the development of institution-level guidance and protection for physicians practicing in states with restrictions potentially interfering with the patient-physician relationship.

Also at the AMA 2024 Interim Meeting, the HOD adopted Policy D-605.982, "Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance," which states:

1. Our American Medical Association's Task Force, to Preserve the Patient-Physician Relationship, will present annual updates on their findings at AMA Annual Meetings until the objectives have been completed.

DISCUSSION OF TASK FORCE ACTIVITIES

Task Force Formation

As directed by the HOD and in response to the U.S. Supreme Court's landmark 2022 decision in *Dobbs v. Jackson Women's Health Organization*, which held that the U.S. Constitution does not confer a constitutional right to abortion and returned the authority to regulate abortion to the states and the subsequent enactment of abortion bans in half the states, the AMA Board of Trustees' (Board) formed the Task Force in June of 2023. With the formation of the Task Force and consistent with AMA Policies G-605.009 and D-5.998, as noted above, the Board envisioned that the Task Force would advise the Board of new and emerging threats to the provision of evidenced-based medical care and appropriate and innovative responses to protect access to care and to preserve the role of the patient-physician relationship as a central element in medical decision-making.

In accordance with the specific language of AMA Policies G-605.009 and D-5.998, in September 2023, the Chairs of the Councils on Legislation, Medical Service, Medical Education, Science and Public Health, and Ethics and Judicial Affairs each appointed two Council members to serve on the Task Force. As a result, 10 Council representatives serve on the Task Force. The Immediate Past Chair of the Board, Willie Underwood III, MD, MSc, MPH, appointed Madelyn E. Butler, MD, AMA Trustee, and Maryanne C. Bombaugh, MD, MBA, MSc, member of the Executive Committee for the AMA Council on Legislation, to serve as Co-Chairs of the Task Force.

In addition, and in accordance with the underlying policy, in the spring of 2024, AMA invited 10 state medical associations and 13 national medical specialty societies to appoint a physician representative to serve on the Task Force. The organizations were selected based on their expertise, experience, and response to an AMA survey fielded in November 2022 (which was described in detail in the 2023 report of the Task Force) that asked about priorities and capacity to engage on the issues identified in AMA Policy G-605.009.

Seven state medical associations and 11 national medical specialty societies nominated a physician representative to serve on the Task Force. The participating national medical specialty societies include:

- American Academy of Child and Adolescent Psychiatry
- American Academy of Dermatology
- American Academy of Family Physicians
- American Academy of Pediatrics
- American College of Emergency Physicians
- American College of Obstetricians & Gynecologists
- American College of Physicians
- American Psychiatric Association
- American Society for Reproductive Medicine
- American Society of Clinical Oncology
- The Endocrine Society

The participating state medical associations include:

- California Medical Association
- Idaho Medical Association

- The Maryland State Medical Society (MedChi)
- Massachusetts Medical Society
- Pennsylvania Medical Society
- Texas Medical Association
- Medical Society of Virginia

In total, there are 29 physician members on the Task Force.

Task Force Meetings

As the Task Force formed, staff across the AMA conducted environmental scans and gaps analyses of the issues identified in Policy G-605.009. These landscape analyses identify implementation-focused practice and advocacy resources on issues including health equity, practice management, medical education, privacy, and legal issues and identify potential resource gaps. The landscape analyses were presented to Council representatives monthly, beginning in January of 2024 and concluding in May of 2024. The landscape analyses were used (and will continue to be used) to identify key topics of discussion for meetings of the Task Force and were distributed to all Task Force members prior to the first in-person meeting of the Task Force.

Since its inception in spring of 2024, the Task Force has held three virtual meetings, two in-person meetings, and one informational session. The virtual meetings were held in May 2024, December 2024, and January 2025. In-person meetings were held in July 2024 and February 2025. The informational session was held at the AMA 2024 Interim Meeting of the HOD in November 2024.

The Task Force held a virtual kick-off meeting on May 2024, in which the Task Force Co-Chairs laid out the Task Force's scope, deliverables, and calendar for upcoming meetings. In December 2024, the Task Force held a meeting to discuss the remarks given at the informational session at the 2024 Interim Meeting of the HOD and discuss ongoing Task Force projects. Then in January 2025, the Task Force met to review research conducted into strategy and messaging. (Note: Additional details about the research discussed in the January meeting is provided later in this report.) The Task Force will continue to schedule virtual meetings as necessary.

The Task Force held its first in-person meeting in July 2024 in Chicago. The in-person meeting focused on legal issues in abortion care and featured a range of speakers and presenters on topics all relating to legal issues in abortion care including, abortion-related litigation activity across the country, legal resources for physicians, the Emergency Medical Treatment and Active Labor Act (EMTALA), and shield law protections for abortion care providers. Following each presentation, Task Force members asked questions and discussed issues and concerns. During a working lunch, Task Force members were asked to strategize and identify resource gaps and potential deliverables for the Task Force regarding advocacy, health equity, medical education and workforce, legal issues, practice issues, and public health. The exercise generated numerous ideas for action. At the conclusion of the day, as directed by the Board and in accordance with Policies G-605.009 and D-5.998, which instruct the Task Force to identify and create implementation-focused practice and advocacy resources, the Task Force discussed existing resources and limitations of those resources, and identified gaps where resources need to be developed.

Following its July meeting, the Task Force hosted an informational session at the AMA's 2024 Interim Meeting to engage with AMA Delegates, Alternate Delegates, and representatives from the AMA Sections. This session was an opportunity to elevate important voices that are not members of the Task Force. At the session, the Task Force co-chairs presented on the Task Force's directives, scope, and activities in 2024. Following the presentation, selected representatives from the AMA's Sections were invited to provide remarks about their experience with laws restricting or banning reproductive health care. The representatives' remarks focused on state laws' impacts on patient care, career and family decisions, educational opportunities, fears for patient outcomes, and, overall, increased physician stress and anxiety. The selected speakers from the AMA Sections represented:

- Women Physicians Section
- Medical Student Section
- Resident and Fellow Section
- Young Physicians Section
- Minority Affairs Section
- LGBTQ+ Section
- Private Practice Physician Section

- Organized Medicine Staff Section
- Academic Physicians Section
- International Medical Graduates Section
- Senior Physician Section

After the representatives from AMA's Sections spoke, other interested parties were invited to ask questions or provide remarks on issues being considered by the Task Force that had not been addressed by previous speakers. These speakers focused their remarks on requests for more communication about the Task Force's work and opportunities for future engagement with the Task Force. To foster continued communication with AMA Delegates, Alternate Delegates, representatives from AMA Sections, and other interested parties, the Task Force plans to host informational sessions at the 2025 Annual and Interim Meetings of the HOD. The Board encourages all interested members to participate in the informational sessions in June and November. In addition to the informational sessions, AMA staff expect to conduct outreach with Sections and specialty groups in the lead up to the HOD meetings and will meet with them at their request.

In accordance with the amendment to Policy G-605.009 adopted at the AMA 2023 Interim Meeting, in summer of 2024 the Task Force formed a subcommittee to focus on payment and reimbursement issues in gender-affirming care for adults. Members of the subcommittee represent the following nine organizations:

- AMA Board of Trustees
- AMA Council on Legislation
- AMA Council on Ethical and Judicial Affairs
- American Academy of Child and Adolescent Psychiatry
- American Academy of Dermatology
- American Psychiatric Association
- American Society for Reproductive Medicine
- The Endocrine Society
- Idaho Medical Association

AMA staff conducted a landscape analysis on payment and reimbursement issues that hinder access to gender-affirming care in adults, which, like the landscape analyses on abortion, identified existing resources and gaps in those resources and helped inform discussion during in-person meetings. The subcommittee met in August 2024 to identify issues in payment and reimbursement for gender-affirming care in adults and plan the topics, structure, and agenda for the Task Force's meeting in February 2025 dedicated to these issues.

One of the issues identified by the subcommittee was challenges arising from CPT® coding for gender-affirming care in adults. As such, the subcommittee collaborated with the LGBTQ+ Section to field a survey to better understand these coding challenges. The input from this survey aided the Task Force's discussion of coding issues during its February 2025 meeting.

As directed by AMA Policy, the Task Force met in February of 2025 in Chicago to "identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care." The meeting featured a range of speakers on topics all involving payment and reimbursement limitations and administrative challenges that impede access to gender-affirming care for adults, including challenges stemming from outdated or inadequate billing codes, inadequate provider networks, low reimbursement rates, discriminatory laws and policies, and state and federal efforts restrict or criminalize access to gender-affirming care. Speakers included physicians who provide gender-affirming care to adult patients, attorneys, coding experts, a state insurance regulator, and a Medicaid expert. The meeting was structured to allow ample time after each presentation for Task Force members to ask questions of the presenters and discuss barriers to care with one another. These discussions focused on the current landscape and highlighted potential pain points for physicians and patients. Much of the discussion also centered around recent federal executive orders to prohibit federal funding of services for minors and the impact those policies could have on care for other populations. In the last session of the meeting, as directed by the Board and consistent with Policy G-605.009, which instructs the Task Force to recommend solutions to these barriers to care, the Task Force members discussed opportunities and strategies for improving access to care and alleviating administrative burden, including working towards updating CPT® codes, continuing to advocate against criminalization, and supporting physicians who care for transgender and gender diverse patients. This discussion was informed by Task Force member's perspectives as clinicians, the speaker's presentations, and discussions throughout

the meeting. Work related to the payment and coding issues raised in this meeting and by the Task Force subcommittee, as it relates to the adult patient population, is ongoing.

Ongoing Projects of the Task Force

As a result of reproductive care resource gaps identified by the Task Force during its July 2024 meeting, AMA, at the direction of the Board, has undertaken a series of projects to fill those gaps, including the development of a resource hub, strategy and message development, research and resources on workforce impact, and development of state law guides.

First, AMA is developing a website to serve as a resource hub for physicians navigating abortion restrictions. The website will exist separately from the AMA's website and will be available to the public. The website will house resources created and developed by the Task Force, as well as resources created and provided by Federation partners and other external organizations. At this time, AMA staff has secured the funding for the website's creation and contracted with a vendor, and creation of the website is in process. The Task Force will inform the HOD when the website is available later this year.

Second, to further refine AMA's advocacy strategy and messaging around abortion restrictions, AMA staff collaborated with a research consulting firm to conduct qualitative research using surveys, in-depth interviews, and focus groups. The research helped explain how different messages, language, and tone resonate across key constituent audiences and build a more compelling narrative for reproductive health advocacy grounded in a strategic messaging foundation. The research provided insight for Task Force members and their organizations on physicians' and the public's perception of the current reproductive health care landscape and will inform strategy for the Task Force going forward. The Task Force met in January 2025 to review the research findings and discuss their implication for Task Force messaging strategy.

To better understand how abortion bans and restrictions impact the physician workforce, AMA staff has initiated a research project examining the impact of abortion restrictions on the physician workforce and where physicians choose to practice. The research and mapping project is scheduled to be completed in spring 2025.
Because of the Task Force's discussions surrounding the need for legal resources for physicians, the AMA has supported the Abortion Defense Network (ADN) and their network of attorneys and law firms that provide legal advice and representation to physicians navigating the post-*Roe* legal landscape. Their resources include 16 in-depth "Know Your State's Abortion Laws" guides for medical professionals, which aim to provide clarification on what conduct is permitted and what the law requires in states with abortion restrictions. The guides cover state laws and professional guidelines on numerous facets of reproductive health care, including medication abortion, contraception, and obligations under EMTALA. In addition to their written legal resources, ADN provides physicians with personalized legal advice and assistance through their hotline. All of these resources are available to physicians and other health care providers at www.abortiondefensenetwork.org, and the AMA is exploring opportunities to support creation of additional ADN resources and further publicize existing resources.

Prompted by the discussions at the Task Force's February meeting, AMA staff is exploring potential next steps related to payment and reimbursement in gender-affirming care in adults, including reviewing and updating existing resources, following up on coding issues, continuing collaboration with state medical associations where appropriate, and supporting physician wellness for physicians navigating challenges in providing gender-affirming care. (Note: Because of approval deadlines, this report was prepared in February 2025 and may not include more recent developments about the Task Force's activities. The Board urges all interested members to participate in the informational session at the 2025 Annual Meeting.)

In addition to these activities, due to the timeliness and prioritization of the issues, the AMA State Advocacy Summit held in January 2025 included a panel of leading staff from state attorneys general offices across the country to highlight ongoing work to protect and promote reproductive health care. The panelists discussed shield laws, programs to link physicians with legal support, and ways state attorneys general can work directly with health care professionals to resolve complaints and mitigate barriers to care. The AMA State Advocacy Summit is held annually to elevate state legislative and regulatory issues and strategies in advance of the upcoming state legislative sessions. Attendees include physician leadership from the AMA, national, state, and specialty medical associations, including the members of the Board, Council members, delegates, and alternate delegates to the HOD, as well executive, health policy, and government affairs staff from organized medicine.

The Task Force continues to consider additional deliverables to support physicians navigating state laws restricting or banning abortion and experiencing challenges related to payment and reimbursement for gender-affirming care. In particular, in accordance with AMA policy passed at the 2024 Interim Meeting, AMA is continuing to meet and collaborate with American College of Obstetricians and Gynecologists on a project to facilitate institutional guidance in states with abortion restrictions. The Task Force is also receiving quarterly updates on litigation activity from the AMA Office of the General Counsel. Additionally, throughout the Spring of 2025, the co-chairs of the Task Force have reached out to and are meeting with various AMA Sections in an effort to continue dialogue, hear concerns, and take back recommendations to the larger Task Force.

Upcoming Meetings of the Task Force

The Task Force will host an informational session at the AMA 2025 Annual Meeting to continue to engage AMA Delegates, Alternate Delegates, and representatives from AMA Sections. This session is an opportunity to elevate important voices that are not members of the Task Force. Attendees of the informational session will hear about the activities of the Task Force and are invited to share their perspective on the issues being considered by the Task Force. The Board encourages all interested members to participate in this informational session.

The Task Force will also host an in-person meeting in July 2025 to discuss the impact of abortion restrictions on education, training, and workforce; an informational session at the 2025 Interim Meeting of the HOD; and an in-person meeting in February 2026 to discuss the intersection of abortion care, health equity, and public health.

CONCLUSION

The Board, through the Task Force, will continue to implement Policies G-605.009 and D-5.998, monitor and prepare for new and emerging threats to the provision of evidenced-based medical care, and work to protect access to care and preserve the role of the patient-physician relationship as a central element in medical decision-making.

13. THE UNIFORM HEALTH-CARE DECISIONS ACT

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

INTRODUCTION

This American Medical Association (AMA) Board of Trustees report arises from Resolution 250-A-24, “Endorsement of the Uniform Health-Care Decisions Act.” As introduced by the Michigan Delegation. Resolution 250-A-24 called upon the AMA to amend policy D-140.968, “Standardized Advance Directives,” as follows:

> Our AMA will endorse the "Uniform Health-Care Decisions Act," which was drafted and adopted by the National Conference of Commissioners on Uniform State Laws (NCCUSL) in ~~1993~~ 2023, and work with our state medical societies to advocate for its adoption in the states.

Testimony in support of Resolution 250-A-24 emphasized that AMA had endorsed the 1993 version of the Uniform Health-Care Decisions Act (UHCDA), that a new and updated version of the UHCDA had been approved in 2023, and that endorsement of the 2023 version was a needed update to AMA policy. Supportive testimony also praised the UHCDA’s new provisions related to end-of-life care. On the other hand, other testimony voiced concern about the UHCDA provisions related to mental health and expressed that the UHCDA inadequately addressed complex issues that would negatively impact medical practice.

Resolution 250-A-24 was referred. This report examines the binary question of whether the AMA should endorse the 2023 UHCDA as adopted by the Uniform Laws Commission (ULC). This report does not seek or recommend changes to the UHCDA.

BACKGROUND

The ULC is a nonpartisan, non-profit association comprised of state commissions on uniform laws from each state. Members of the ULC are licensed attorneys. The ULC's purpose is "to study and review the law of the states to determine which areas of law should be uniform [and] promote the principle of uniformity by drafting and proposing specific statutes in areas of the law where uniformity between the states is desirable."[1] Importantly, the ULC drafts model legislation, but the legislation must be enacted by a state legislature to be effective.

In 1993, the ULC, then known as the National Conference of Commissioners on Uniform State Laws, promulgated the UHCDA, a third-generation model bill that addressed advance health care directives and health care decision-making on behalf of patients lacking capacity. Subsequently, the AMA adopted policy to endorse the 1993 UHCDA. Six states (Alaska, Hawaii, Maine, Mississippi, New Mexico, and Wyoming) enacted the 1993 UHCDA. In 2020, the ULC appointed a drafting committee to modernize and expand the UHCDA, and in 2023 the ULC approved and recommended the 2023 UHCDA for enactment in all states.

The 2023 UHCDA governs powers of attorney for health care, advance directives, and other forms of health care instructions intended to inform health care professionals and agents about a patient's wishes, priorities, and values regarding health care decisions made for them when they are unable to make such decisions themselves. The UHCDA also governs determination of capacity, judicial review, and appointment of surrogate decisionmakers when there is no advance directive. In addition, the UHCDA establishes certain duties and powers of agents and health care professionals and shields them from liability when they act reasonably and in good faith.

Among the changes in the 2023 UHCDA is the authorization of advance directives specifically for mental health care. These directives enable individuals to provide specific instructions reflecting their preferences for mental health care and/or to authorize an agent to make mental health care decisions on their behalf. The provisions also allow an individual to limit their own ability to revoke an advance mental health care directive when experiencing an acute mental health event.

To date, one state (Delaware) has enacted the 2023 UHCDA.

AMA POLICY

As noted earlier in this report, AMA Policy D-140.968, "Standardized Advance Directives," endorses the 1993 UHCDA and urges state medical societies to advocate for its adoption.

Policy H-85.957, "Encouraging Standardized Advance Directives Forms Within States," encourages each state medical society to develop a standardized form of advance directives for use by physicians and other health care providers as a template to discuss end-of-life care with their patients.

Policy H-140.845, "Encouraging the Use of Advance Directives and Health Care Powers of Attorney," states that AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on

advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives.

Policy H-85.956, "Educating Physicians About Advance Care Planning," supports efforts to increase the prevalence and quality of meaningful advance care planning, including the use of advance directives, to improve recognition of and adherence to a patient's advance care decisions, the development of materials to educate physicians, patients and others about advance care planning and the requirements and implications of the Patient Self-Determination Act, and patient education resources. The Policy also encourages medical schools and residency programs to increase awareness of advance care planning and educate trainees about the use of such tools.

Policy H-140.970, "Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients," states that: (1) Advance directives (living wills and durable powers of attorney for health care) are the best insurance for individuals that their interests will be promoted if they become incompetent. Generally, it is most effective if the individual designates a proxy decisionmaker and discusses with the proxy his or their values regarding decisions about life support. (2) Without an advance directive that designates a proxy, the patient's family should become the surrogate decisionmaker. Family includes people with whom the patient is closely associated. In the case when there is no person closely associated with the patient, but there are people who both care about the patient and have some relevant knowledge of the patient, such relations should be involved in the decision-making process and may be appropriate surrogates. (3) It is the responsibility of physicians to provide all relevant medical information and to explain to surrogate decisionmakers that decisions should be based on substituted judgment (what the patient would have decided) when there is evidence of patients' preferences and values. If there is not adequate evidence of preferences and values, the decision should be based on the best interests of the patient (what outcome would most likely promote the patient's well-being). (4) Institutional ethics committees should be established for the purpose of facilitating sound decision-making. These ethics committees should be structured so that a diversity of perspectives, including those from outside medicine, are represented. (5) The surrogate's decision should almost always be accepted by the physician. However, there are four situations that may require either institutional or judicial review and/or intervention in the decision-making process. These situations are when: (a) there is no available family willing to be the patient's surrogate decisionmaker; (b) there is a dispute among family members and there is no decisionmaker designated in an advance directive; (c) a health care provider believes that the family's decision is clearly not what the patient would have decided if competent; and (d) a health care provider believes that the decision is not a decision that could reasonably be judged to be in the patient's best interests. Decisions based on a conflict of interest generally would not be in the patient's best interest. In these four cases, the guidelines outlined in the report should be followed. When there are disputes among family members or between family and health care providers, the use of ethics committees specifically designed to facilitate sound decision-making is recommended before resorting to the courts. (6) Judicial reviews for decisions about life-sustaining treatment should be a last resort. It is strongly encouraged that when judicial review is necessary, in nonemergency situations, the courts should determine who is to make treatment decisions, including appointing a guardian, rather than making treatment decisions. (7) When a permanently unconscious patient was never competent or had not left any evidence of previous preferences or values, since there is no objective way to ascertain what would be in the best interests of the patient, the surrogate's decision should not be challenged as long as the decision is based on the decisionmaker's true concern for what would be best for the patient. (8) In the case of seriously ill or handicapped newborns, present and future interests of the infant must be considered. Due to the complexities involved in deciding about life support for seriously ill newborns, physicians should specifically discuss with parents the risks and uncertainties involved. When possible, parents should be given time to adjust to the shock of the situation and absorb the medical information presented to them before making decisions about life-sustaining treatment. In addition, counseling services and an opportunity to talk with couples who have had to make similar decisions should be available to the parents. (9) Due to the complexity of decisions for permanently unconscious patients and newborns, an ethics committee should be available, whenever possible, to facilitate the surrogate's decision-making. (10) Hospitals and other health care facilities should establish protocols regarding assessment of decision-making capacity, informing patients about advance directives, identifying surrogate decisionmakers, the use of advance directives, substituted judgment and best interests in decision-making, and the procedures for challenging the decision of a surrogate. These protocols should be in accordance with the CEJA preceding guidelines.

Policy H-85.952, "Advance Directives During Pregnancy," affirms the patient-physician relationship as the appropriate locus of decision making and the independence and integrity of that relationship, promotes awareness and understanding of the ethical responsibilities of physicians with respect to advance care planning, the use of advance directives, and surrogate decision making, regardless of gender or pregnancy status, set out in the Code of Medical

Ethics, and recognizes that there may be extenuating circumstances which may benefit from institutional ethics committee review, or review by another body where appropriate.

Finally, AMA Policy H-140.826, "Use of Psychiatric Advance Directives," recognizes the potential for advance care planning to promote the autonomy of patients with mental illness and urges the mental health community to continue to study the role of advance care planning in therapeutic relationships and the use of psychiatric advance directives to promote the interests and well-being of patients, and support efforts to increase awareness and appropriate utilization of psychiatric advance directives.

DISCUSSION

Advance care planning is an important aspect of ensuring patient treatment preferences are respected in the event the patient is unable to communicate their wishes. Central to respecting patient autonomy at the end of life or during incapacity is the use of advance directives, a health care power of attorney, and other advance care planning instruments. However, laws governing these instruments may vary across states and this inconsistency can create confusion, complexity, and barriers to effective health care decision-making, ultimately undermining the very goals of advance care planning. A uniform approach among state laws could help minimize confusion and inconsistency and promote high-quality patient care and effective communication and decision-making between patients, families, and health care professionals, particularly in cases when medical decision-making may occur across state lines, amidst conflict between family members or when a patients' preferences have not been made clear. The UHCDA provides a framework for the creation, execution, and recognition of advance care planning tools, the delegation of health care decision-making, and the relevant duties of agents and health care providers. Indeed, existing AMA policy aligns with the goals of the UHCDA. However, inconsistencies between the UHCDA, AMA policy, and clinical practice raise concerns about whether broad endorsement of the UHCDA is appropriate for the AMA.

One critical criticism of the 2023 UHCDA centers around determinations of patient capacity to make health care decisions, and the lack of clear guidelines for complex medical scenarios. Specifically, under the UHCDA, the determination of capacity requires consideration of two criteria: (1) whether an individual is willing and able to communicate a decision and (2) whether the individual understands the nature and consequences of making or revoking a decision or instruction. In contrast, the widely accepted assessment of decisional capacity in clinical practice, which has been incorporated into state laws, assesses four skills: whether the individual is able to understand relevant information; appreciate the clinical circumstances; exhibit a rational process of decision making; and communicate a consistent choice.[2] While the approaches are not necessarily in conflict in all cases, the UHCDA approach could, particularly with regard to psychiatric care, conflict with the accepted medical standard for assessing capacity. This could lead to confusion among health care professionals and in application in the courts.

Additionally, some UHCDA provisions directly conflict with existing AMA policy. For example, AMA Policy H-140.970, "Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients," states that, in the absence of an advance directive, the patient's family should become the surrogate decisionmaker regarding decisions to forgo life-sustaining treatment, whereas the UHCDA first prioritizes "an adult the individual has identified, other than in a power of attorney for health care, to make a health-care decision for the individual if the individual cannot make the decision" before family. AMA policy also identifies when decisions to forgo life-sustaining treatment warrant institutional or judicial review, including when there is a dispute among family members and no designated decisionmaker, and when there is no available family willing to be the patient's surrogate decisionmaker. In contrast, the UHCDA instructs health care providers to comply with the decision of a majority of the family members when there is a dispute and authorizes non-family members to function as surrogate decisionmakers according to a priority list. AMA policy also advocates for use of institutional ethics committees, whereas the UHCDA makes no mention of ethics committees. The UHCDA also authorizes and promotes use of mental health advance directives, whereas AMA policy merely recognizes the potential benefit of mental health advance directives and urges further study.

The UHCDA also conflicts with AMA policies that vigorously support and advocate for appropriate physician supervision of non-physician clinical staff in all areas of medicine. Specifically, the UHCDA authorizes a "responsible health-care professional" to determine whether a patient lacks capacity when a physician, psychologist, physician assistant, advanced practice registered nurse, or social worker is unavailable, and a prompt decision is necessary to avoid loss of life or serious harm. The UHCDA does not require the "responsible health-care professional" to have any specific training, expertise, or license. AMA Policy H-160.949, "Practicing Medicine by Non-Physicians," expressly opposes state legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision.

It is critical to note that AMA does not endorse the actions of other organizations with which it does not completely and wholly agree. Though individuals may disagree about the appropriate weight to be given to the concerns and conflicts discussed in this report, the Board of Trustees (the Board) finds the lack of perfect alignment determinative. Therefore, the Board recommends against endorsement of the UHCDA. Additionally, adoption of the 2023 UHCDA by the ULC renders AMA Policy D-140.968, "Standardized Advance Directives," outdated and the policy should be rescinded.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 250-A-24 and the remainder of the report be filed.

1. That Policy D-140.968, "Standardized Advance Directives," be rescinded. (Rescind HOD Policy)

Fiscal Note: Less than $500

REFERENCES

1 "About Us", Uniform Laws Commission, available at https://www.uniformlaws.org/aboutulc/overview
2 Paul S. Appelbaum & Thomas Grisso, Assessing patients' capacities to consent to treatment, 319 NEJM 25, 1635-8 (Dec. 1988); Jacob M. Appel, The Statutory Codification of Decisional Capacity Standards, 51 J Am Academy Psych & Law 4, 506-519 (Dec. 2023).

14. A PUBLIC HEALTH-CENTERED CRIMINAL JUSTICE SYSTEM

Reference committee hearing; see report of Reference Committee B.

HOD ACTION: **RECOMMENDATIONS ADOPTED**
REMAINDER OF REPORT FILED
See Policies D-430.992, H-80.993, H-95.899, H-95.901 and H-430.972

INTRODUCTION

Resolution 215-I-23, "A Public Health-Centered Criminal Justice System," introduced by the Medical Student Section was referred. This resolution asked that that our American Medical Association:

> support legislation that reduces the negative health impacts of incarceration by: a. advocating for decreasing the magnitude of penalties, including the length of prison sentences, to create a criminal justice model focused on citizen safety and improved public health outcomes and rehabilitative practices rather than retribution, b. advocating for legislation and regulations that reduce the number of people placed in prison conditions, such as preventing people who were formerly incarcerated from being sent back to prison without justifiable cause, and c. supporting the continual review of sentences for people at various time points of their sentence to enable early release of people who are incarcerated but unlikely to pose a risk to society; and
>
> (1) recognize the inefficacy of mandatory minimums and three-strike rules and the negative consequences of resultant longer prison sentences to the health of incarcerated individuals, and (2) support legislation that reduces or eliminates mandatory minimums and three-strike rules.

BACKGROUND

The U.S. incarcerates nearly two million people, far more than any other country in the world.[1] The problem of mass incarceration in the U.S. is not just a function of the number of people in prison—or the larger number of people who cycle in and out of correctional facilities every year but also a function of the length of time the system incarcerates people. Retribution, deterrence, incapacitation, and rehabilitation are all concepts that have been central to sentencing theory, policy, and practice over the last two centuries.[1]

As of 2019, 57 percent of the U.S. prison population was serving sentences of 10 or more years.[1,2] As of 2020, one in seven people in U.S. correctional facilities was serving a life sentence.[1,3] In 2022, the Council on Criminal Justice, examining National Corrections Reporting system data, found that from 2005 to 2019 the percentage of people serving sentences of 10 or more years in state correctional facilities grew substantially, reaching 57 percent of the total population in 2019.[1,4] On any given day, there are nearly 1.7 million people serving sentences in prison and jail, almost 500,000 more detained in jail pretrial, another 4.4 million under some form of probation or parole control, and between 70 and 100 million marked with a record of arrest or conviction.[1,5,6,7] This level of incarceration reaches into more than 100 million U.S. households: half of all adults in the U.S. have had a family member detained at least overnight.[1,8] Black and Latinx people make up 58 percent of the U.S. prison population but just 31 percent of the nation's overall population.[1,9,10] Among those serving life and "virtual life" sentences—sentences of 50 years or more—nearly half are Black, and another 16 percent are Latinx.[1,11] One in five Black men in prison is serving a life sentence.[12] Black men receive harsher sentences and serve more time in prison compared to white men—in the federal system, for example, their sentences are 19.1 percent longer—even after controlling for factors like conviction history, education, and income.[1,12] In the same system, Black people are also 21.2 percent less likely to receive a sentence shorter than advised by the sentencing guidelines than white people.[1,12] In the last 20 years, however, racial disparities have dropped as the number of White people in prison continues to increase while the number of Black people drops.[1,13]

Incarceration and Health

It is well documented that justice-involved people have a higher prevalence of acute and chronic health conditions than the general U.S. population.[14] This includes higher rates of infectious diseases, mental health diagnoses, substance use disorders, traumatic brain injuries, hypertension, heart-related problems, diabetes, asthma, and stroke, along with overall lower life expectancy.[15,16,17] The higher prevalence of these acute and chronic conditions among incarcerated people has been partially attributed to pre-incarceration exposure to adverse structural determinants such as poverty and unstable housing.[15] However, the experience of incarceration itself is also associated with adverse health outcomes.[16-17] Violence—whether self-directed, interpersonal, or perpetrated by agents of the state—is also a significant documented harm of incarceration.[18] While men are more likely to experience interpersonal violence from another justice-involved person, women are more likely to be assaulted by staff.[18,19] Strikingly, transgender people are targeted at nearly 10 times the rate of other justice-involved people.[18,20] In addition to widespread violence and sexual assault inside carceral settings, other extreme human rights violations such as mass forced sterilizations, regular use of solitary confinement, and abandonment during natural disasters are known harms linked to incarceration.[18,21]

In addition to direct health consequences experienced by justice-involved people, the harms of the carceral system extend to families and communities of justice-involved people through mechanisms such as family separation and disruption of community cohesion.[22] For example, parental/caregiver incarceration is associated with food insecurity during childhood and a greater risk of living with mental health issues in childhood and adolescence.[23] If incarcerated pregnant people have children or give birth while incarcerated, the harm from incarceration is carried through generations even after release.[23] These detrimental consequences also extend to adult partners and relatives, inducing relationship strain and onset of depression and anxiety.[24] Some of the carceral system's harms are indirectly mediated through pathways such as added economic pressures (e.g., household income loss and paying for fees and fines) and housing precarity, which have been linked to adverse health outcomes.[25]

A Public Health Approach to Criminal Justice

A public health-centered approach to the criminal justice system is focused on prevention and early intervention and prioritizes addressing structural determinants such as poverty, education, employment, and environment that shape the prevalence of incarceration and increase the risk of adverse health outcomes.[26] These prevention strategies include providing equitable access to resources that communities need to thrive, including stable and supportive housing, affordable high-quality education starting in early childhood, well-paying employment, culturally responsive youth programs, and affordable and accessible health care (including access to mental health first responders and within-community mental health services).[26,27] A public health approach emphasizes treatment for those facing mental health crises or substance use disorders rather than incarceration to help address underlying conditions. For those who are incarcerated, providing comprehensive health care services during incarceration, and linking people to services post release can help improve health and well-being. Rehabilitation and reentry programs are also vital to help individuals reintegrate into society post-release. It is also important to evaluate the effectiveness of these interventions to understand the impact not only on justice-involved individuals, but also on public safety and the overall health of communities. There is also a significant lack of support for women once they are released. There are fewer options for job training, fewer housing options, and often incarcerated women have less support systems when released

compared to men.[28] Creating reentry programs tailored to women's needs is essential and these programs should focus on trauma-informed care, parenting support, and vocational training to address the unique challenges women face.[28]

Restorative Justice Approaches

Restorative justice is a nonpunitive, nonretributive process to address interpersonal harm that centers survivors of harm and brings together everyone affected to decide collectively how to heal and to repair harm.[29] Transformative justice builds upon this process by focusing not only on the individuals involved but also on the larger systems and structures that created the conditions for that harm to occur.[30] Although restorative and transformative justice processes vary widely in implementation, making evaluation of their effectiveness challenging, research on restorative justice shows it to be a promising solution to the problem of incarceration.[30] For example, one of the most comprehensive meta-analyses on restorative justice revealed higher levels of satisfaction among individuals involved in the process (including those who were harmed and those who did harm), a greater likelihood of adhering to restorative agreements, and decreased rates of recidivism relative to those who did not participate in a restorative justice process.[31] Another meta-analysis of restorative justice programs with young people less than 18 years of age showed a general trend of decreased reengagement with the legal system, a greater sense of fairness among both the young people who did harm and the people who were harmed, and greater satisfaction in comparison with those who did not participate in a program.[32] These outcomes suggest better mental well-being for all individuals involved when a restorative justice process is used as an alternative to the carceral system.[30,31] Preliminary evidence suggests that restorative justice approaches provide a more effective and less harmful means of accountability than continuing to invest in punitive paradigms.[18,30,31]

SENTENCING IN THE U.S.

Sentencing in criminal law refers to the process of determining the appropriate punishment or penalty for a person who has been convicted.[33] It typically involves taking into consideration factors, such as the nature and severity of the crime, the defendant's criminal history, and any mitigating or aggravating circumstances.[32] Retribution, deterrence, incapacitation, and rehabilitation are all concepts that have been central to sentencing theory, policy, and practice over the last two centuries.[32] The federal courts and some states have sentencing guidelines to guide judges in determining appropriate sentences and to encourage uniformity.[32]

Near the end of the 20th century, states and the federal government passed sentencing laws and policies that resulted in increasing incarceration rates in the U.S.[33] These laws fell into four main categories—mandatory minimums, "truth in sentencing," new and longer enhancements based on prior criminal convictions (such as "three-strikes" laws and other "habitual offender" laws), and laws that restricted parole release, such as life without parole sentences.[1,34] This report is focused on mandatory minimum sentences, including three strike laws, as they fall within the purview of the original resolution.

MANDATORY MINIMUM PENALTIES & SENTENCING ENHANCEMENTS

All 50 states, the District of Columbia, and the federal government require a judge to order a set minimum period of incarceration if a person is convicted of certain crimes.[1,35] Mandatory minimums, limit judges' discretion to consider a person's individual circumstances.[1,34] On the federal level, the term "mandatory minimum penalty" requires, upon conviction of a federal criminal offense and the satisfaction of criteria set forth in that statute, the imposition of a specified minimum term of imprisonment.[36] Mandatory minimum penalties vary in length depending on the offense type and specified criteria, from two years for aggravated identity theft, to life in prison for certain drug trafficking offenses. The statutory criteria that trigger mandatory minimum penalties can be classified into at least one of three categories: (a) penalties triggered by offense characteristics or elements of the offense of conviction; (b) penalties triggered by reference to another underlying offense; or (c) penalties triggered by the offender's criminal history.[35]

Not all offenders convicted of an offense carrying a mandatory minimum penalty are sentenced to the minimum term of imprisonment specified in the statute of conviction.[35,37] Under the current system, a sentencing court can impose a sentence below an otherwise applicable statutory mandatory minimum penalty if: (1) the prosecution files a motion based on the defendant's "substantial assistance" to authorities in the investigation or prosecution of another person who has committed an offense; or (2) in certain drug trafficking cases, the defendant qualifies for the statutory "safety valve" contained in 18 U.S.C. § 3553(f).[35,36,38]

Unlike a substantial assistance departure—which applies to all types of federal offenses carrying a mandatory minimum penalty—the safety valve statute only applies in cases in which a defendant faces a mandatory minimum penalty after being convicted of a drug trafficking offense listed in the statute.[35,39] In addition, the safety valve only applies if the following five criteria are met:

- the defendant does not have more than one criminal history point, as determined under the sentencing guidelines;
- the defendant did not use violence or credible threats of violence or possess a firearm or other dangerous weapon (or induce another participant to do so) in connection with the offense;
- the offense did not result in death or serious bodily injury to any person;
- the defendant was not an organizer, leader, manager, or supervisor of others in the offense, as determined by the sentencing guidelines and was not engaged in a continuing criminal enterprise; and
- no later than the time of the sentencing hearing, the defendant has truthfully provided to the Government all information and evidence the defendant has concerning the offense or offenses that were part of the same course of conduct or of a common scheme or plan, but the fact that the defendant has no relevant or useful or other information to provide or that the government is already aware of the information shall not preclude a determination by the court that the defendant has not complied with this requirement.[35-38]

Where these criteria are met, judges shall impose a sentence without regard to the statutory mandatory minimum penalty for the covered offenses.[35,38] The drug trafficking guideline also provides for a 2-level decrease if the defendant meets the safety valve subdivision criteria.[40] This decrease applies regardless of whether the defendant was convicted of an offense carrying a mandatory minimum penalty.[41] It should also be noted that states have mandatory minimum sentencing laws as well, but these vary state by state.[42] Successful state reforms to mandatory minimum sentencing are summarized in Appendix I. Ultimately, federal mandatory minimums result in longer incarceration because few ways around them exist, except via safety valve provisions or substantial assistance motions as mentioned above.

Three Strike Laws

Three strike laws are a criminal sentencing structure in which significantly harsher punishments are imposed on repeated offenders.[43] These laws generally mandate a life sentence for the third violation of violent felonies. These types of laws originated from the Violent Crime Control and Law Enforcement Act of 1994.[44] The federal three strikes statute punishes a defendant with "mandatory life imprisonment if he or she is convicted in federal court of a 'serious violent felony' and has two or more prior convictions in federal or state courts, at least one of which is a 'serious violent felony.'[43] The other prior offense may be a 'serious drug offense.'"[43] The "serious violent felony" includes murder, manslaughter, sex offenses, kidnapping, robbery, and any offense punishable by 10 years or more which includes an element of the use of force or involves significant risk of force.[43]

At the federal level, the First Step Act has eased the mandatory minimum sentencing imposed under the three strikes law.[44] Previously, a person with two or more prior convictions involving a "serious violent felony" or "serious drug felony" was punishable with life imprisonment without parole.[44] Now, this sentence is reduced to 25 years in prison and the sentence for the first offense is reduced from 20 years to 15 years in prison.[44] This reform has given more discretion to judges.[44] The Bureau of Prisons reports that the federal prison population is declining, thanks to the First Step Act.[45] However, a significant portion of the prison population resides in state correctional facilities.[44] Currently, 28 states have enacted the three strikes law.[46] Moreover, some states have a "two-strikes provision," where a subsequent strike-able offense is punishable with twice the term of its ordinary term.[45] In a few states, someone can be released on parole after serving a certain number of years in prison.[45]

ARGUMENTS IN SUPPORT OF MANDATORY MINIMUMS

Promotion of Uniformity in Sentencing and Avoidance of Unwarranted Disparity

Some view mandatory minimum penalties as promoting uniformity and reducing unwarranted disparities because such penalties require courts to impose similar sentences for similar offenses.[47,48] Congress enacted many mandatory minimum penalties, together with the then-mandatory guidelines system, as part of its effort in the 1980s to narrow judicial sentencing discretion and curb what it viewed as unduly disparate and lenient sentences.[49] According to some scholars, the importance of mandatory minimum penalties in ensuring uniformity has increased. The Department of Justice has observed that sentencing disparities have increased under the advisory guidelines system because for "offenses for which there are no mandatory minimums, sentencing decisions have become largely unconstrained as a

matter of law."[50] This has led to greater variation in sentencing, which in turn "undermines the goals of sentencing to treat like offenders alike, eliminate unwarranted disparities in sentencing, and promote deterrence through predictability in sentence."[51] Furthermore, some prosecutors have charged offenses carrying mandatory minimum penalties to narrow the sentencing court's discretion.[52]

Protection of the Public through Certainty in Punishment, Deterrence, and Incapacitation

Law enforcement officials have historically urged the enactment of mandatory minimum penalties.[52] It is believed by some that mandatory minimum penalties deter crime by imposing certain, predictable, and generally severe punishment.[53] Because mandatory minimum penalties require a certain term of incarceration, they are viewed as "an effective means of alerting would-be offenders to the consequences of certain illegal conduct."[54] According to the Department of Justice, sentencing reforms in the 1980s, including the enactment and enhancement of many mandatory minimum penalties, helped reduce crime rates.[48] Some prosecutors and police officers report that the certainty of punishment provided by mandatory minimum penalties is "critical" to law enforcement efforts.[55] Furthermore, some believe that the severity of mandatory minimum penalties increases their deterrent effect by raising the "cost" of committing crime to would-be offenders.[56] In addition to their deterrent effect, some policymakers assert that mandatory minimum penalties reduce crime by incapacitating criminals and protecting the public from their potential future offenses.[57] For example, law enforcement officers have reported that incapacitation through mandatory minimum penalties has reduced methamphetamine- and firearm-related crime.[58]

Effective Law Enforcement Tool that Induces Pleas and Cooperation

The threat of a mandatory minimum penalty gives law enforcement leverage over defendants, who may be encouraged to cooperate in exchange for lesser charges or safety valve and substantial-assistance benefits.[59] Some have stated that the potential application of more severe penalties in federal court "has convinced a number of suspects to give up information."[60] Similarly, the Department of Justice views mandatory minimum penalties as an essential and critical tool in obtaining cooperation from members of "violent street gangs and drug distribution networks."[59]

Assistance to State and Local Law Enforcement

Another justification for federal mandatory minimum penalties relates to the relationship between state and federal law enforcement.[61] Due to the substantial concurrent state and federal jurisdiction in many drug and firearm cases, if a state sentence for a crime is inappropriately low, the existence of a substantially higher, federal mandatory minimum can help ensure a sentence that protects the public.[60] The prospect of being convicted under a federal statute carrying a mandatory minimum penalty can induce defendants to plead to state charges.[60]

ARGUMENTS IN OPPOSITION OF MANDATORY MINIMUMS

Contribution to Excessive Uniformity and Unwarranted Disparity

One of the weaknesses of mandatory minimums is that they apply one-size-fits-all sentences to defendants who are not equally liable.[62] According to the American Bar Association (ABA), "[t]reating unlike offenders identically is as much a blow to rational sentencing policy as is treating similar offenders differently."[63] Mandatory minimum penalties may result in arbitrary and disparate sentences because they rely on certain specified triggering facts.[64] For example, so-called "sentencing cliffs" occur when an offender's "conduct just barely brings them within the terms of the mandatory minimum.[65] In such a case, the offender is subject to a significantly higher sentence than an offender whose conduct fell just outside the scope of the mandatory minimum penalty, even though their conduct was only marginally different.[66] For example, a defendant convicted of trafficking 100 grams of heroin would be subject to the five-year mandatory minimum penalty while one who sold only 99 grams of the drug would not, meaning that these defendants are subject to substantially different sentences despite nearly identical conduct.[67] A majority of judges believe that mandatory minimum penalties contribute to sentencing disparity. In a survey of United States District Judges on a range of sentencing issues, 52 percent of judges ranked mandatory minimum penalties among the top three factors contributing to sentencing disparity.[68] In contrast, 78 percent believed that the sentencing guidelines have reduced unwarranted sentencing disparities among similarly situated defendants.[67]

Excessive Severity and Disproportionality

Many scholars view current federal mandatory minimum penalties as producing sentences that are excessively harsh relative to the gravity of the offense committed, in part because "all sentences for a mandatory minimum offense must be at the floor or above regardless of the circumstances of the crime."[69] The Department of Justice has stated that there are real and significant excesses in terms of the imprisonment meted out for some offenders under existing mandatory sentencing laws, especially for some non-violent offenders.[70] The Department of Justice explained that "[m]andatory minimum sentencing statutes in the federal system now apply to a significant array of serious crimes; and they also, by and large, mandate very severe imprisonment terms."[69] This, in turn, has produced exponential growth in the federal prison population since the 1980s, and the federal Bureau of Prison's overcapacity "has real and detrimental consequences for the safety of prisoners and guards, effective prisoner reentry, and ultimately, public safety."[69] For this reason, the Department of Justice suggests some reforms of existing mandatory minimum sentencing statutes to eliminate excess severity in current statutory sentencing laws and to help address the unsustainable growth in the federal prison population.[69]

Lack of Individualized Sentencing

Critics often argue that mandatory minimum penalties conflict with the goal of individualized sentencing.[71] For instance, the Judicial Conference has long urged Congress "to reconsider the wisdom" of mandatory minimum penalties because they "block judges from considering the individual circumstances of particular cases."[72,73] Because mandatory minimum penalties may prevent a judge from considering all (or even most) of the pertinent facts and circumstances of the case (such as offender characteristics), the resulting sentence may be unfair or irrational.[70-72] Likewise, the American Bar Association has also called for the repeal of federal mandatory minimum penalties after concluding that they are "inconsistent with the notion of individualized sentencing within a guided discretion regime."[71,72] Moreover, there is significant agreement with the Judicial Conference and the ABA among judges and lawmakers, practitioners, scholars, and advocacy groups.[74]

Ineffectiveness as a Deterrent or as a Law Enforcement Tool to Induce Pleas and Cooperation

Some scholars counter the claims made by proponents of mandatory minimum penalties
that these penalties serve as an effective deterrent to crime.[75] Research conducted by social scientists and public policy analysts has found little evidence to support the argument that mandatory minimums prevent crime.[76] In fact, many assert it is an increase in the certainty of punishment through the prosecution of more offenders that is the more cost-effective deterrent compared to the severity of punishment that mandatory minimum penalties or longer sentences provide.[77] Some also dispute the claims that mandatory minimum penalties are a useful law enforcement tool for the investigation and prosecution of criminals by inducing pleas and cooperation. Others have also argued that mandatory minimum penalties are inefficient investigative tools.[78] Some further believe that mandatory minimum penalties cause a "cooperation backlash" that occurs "when sentencing practices are viewed as overly severe" and "many citizens become reluctant to assist the law enforcement effort."[77] Therefore, while mandatory minimum penalties can increase cooperation by offenders who face those punishments, they can hinder the willingness of citizens to cooperate with law enforcement at the early stages of investigation and arrest.[77]

Disproportionate Impact Across Demographic Groups

Some scholars express concerns that mandatory minimum penalties unfairly impact racial minorities and the economically disadvantaged.[79] This may be attributed in part to the fact that the most frequently applied mandatory minimum penalties are for drug offenses, which according to some, disproportionately impacts certain racial or ethnic groups.[80] While acknowledging that this disproportionate impact may be more a function of law enforcement priorities rather than sentencing policy, some assert that mandatory minimum penalties are being applied most frequently to a population that is not necessarily representative of all people violating such laws.[81] They argue that this perceived uneven application creates perceptions of unfairness that undermine the public's acceptance of the criminal justice system.[80] Some also view legally relevant factors, such as criminal history and prosecutorial discretion in charging decisions or plea agreements, as contributors to the demographically disparate impact of mandatory minimum penalties.[80] Studies show that racial minorities are more likely than whites to have a prior record, which may result from disproportionate processing by the criminal justice system.[82] Research likewise indicates that offenders in certain racial groups may be less likely to get the benefit of prosecutorial discretion in charging decisions or plea agreements.[81]

Limited impact on reducing crime rates

Evidence across the U.S. shows there is no discernable relationship between incarceration rates and crime rates: cities with high incarceration rates do not have lower crime rates than cities with low incarceration rates.[1,83] Mandatory minimums have been justified as an incapacitation strategy for people who have committed violent crimes based on the assumption that they are likely to continue to do so.[1,81,82] Research also shows that people "age out" of crime.[1,84] Violent crime, measured by arrest rates, is much more prevalent among younger people from their late teens to early twenties.[1,83] The rate of arrest for such crimes begins to sharply decline after this point and is more than halved by the mid-thirties.[1,85] This means that people who commit crimes, even if they once presented a danger to others, may be safely released much before the end of the 20-, 30-, and 40-year or life sentences they are now serving.[1,84] Additionally, a substantial body of research demonstrates that incarceration of any length is developmentally harmful for young people and contradicts safety, increasing the risk of future involvement with the criminal legal system rather than reducing crime.[1,86] Increases in the number and length of prison and jail sentences have not produced more public safety, because most justice-involved people are not a danger to the community.[1,84,85] A tiny fraction of people commit the majority of violent crimes in the U.S.—according to the data, 1 to 5 percent of people engaged in unlawful behavior commit 50 to 75 percent of all violent crimes.[1,87]

Counterproductive for public safety

Long-term sentences produce diminishing returns for public safety as individuals "age out" of the high-crime years; such sentences are particularly ineffective for drug crimes as drug sellers are easily replaced in the community; increasingly punitive sentences add little to the deterrent effect of the criminal justice system; and mass incarceration diverts resources from program and policy initiatives that hold the potential for greater impact on public safety.[1,82-86] Further, removing large numbers of people, mostly men, from their communities and placing them in correctional facilities for years at a time creates more harm than good.[1,88] Not only does the loss of these primary relationships cause trauma, but employers also lose employees, churches lose members, and neighborhood groups lose contributors.[1,87] A meta-analysis of 116 studies found that custodial sentences not only do not prevent reoffending, but they can also actually increase it.[1,89] Data suggests that incarceration itself can be "criminogenic"—that the prison environment, separation from community, or even the process of returning to the community is so destabilizing that it increases the likelihood of continued encounters with the criminal legal system.[1,90]

Increases cost of incarceration

Scholars argue that if mandatory sentences for nonviolent and drug offenders were necessary for public safety, their cost would be justified.[91] However, as corrections spending has climbed, most experts have come to believe incarcerating huge numbers of low-level, nonviolent and drug offenders post-conviction is an inefficient and ineffective method of controlling crime.[90] While public safety benefits of incapacitating dangerous individuals justifies the costs, according to the Pew Center on the States, "most criminologists now consider the increased use of prison for nonviolent offenders a questionable public expenditure, producing little additional crime control benefit for each dollar spent."[92] A study looked at the cost effectiveness of mandatory minimum drug laws and asserted: "[I]f reducing consumption or violence is the goal, more can be achieved by spending additional money arresting, prosecuting, and sentencing dealers to standard prison terms than by spending it on sentencing (fewer) dealers to longer, mandatory terms."[93] As a result, many states have adopted evidence-based, cost-effective sentencing reforms. For instance, prosecutors in Michigan suggested to legislators that the state was "warehousing too many low-level nonviolent offenders with a minimal role in the drug trade for too long in costly prison beds."[94] As a result, Michigan repealed most of its drug-related mandatory minimums. Prison admittances fell and Michigan saved billions in tax dollars.[93] More importantly, the crime rate fell 27 percent in the decade after the repeal. Other states have moved in a similar direction.[93]

PROPOSED REFORMS TO ADDRESS LONG SENTENCING

Removing extensions of sentences based on prior convictions

Most states have prior conviction enhancements, which increase the probability and length of prison sentences for each felony conviction a person has on their record.[1,95] However, experts argue that sentence enhancements based on prior conviction history are problematic on at least three grounds: they do not promote safety, they are one of the major drivers of racial disparities in sentencing, and they punish people disproportionately for their behavior.[1,94] Policymakers often support prior record enhancements by using a deterrence argument: they claim that people will be

deterred by knowing that if they commit a crime again, they will be punished more severely.[1,96] But increasing the severity of punishment based on a person's previous convictions does not effectively deter future criminal behavior as mentioned above.[1,97] Scholars argue that people who engage in repeated acts of serious harm—the 1 to 5 percent subset of the people who have committed violence— are perhaps the intended focus for proposed incapacitation, but suggest there are targeted ways to address these people, such as requiring specific findings of patterned harm at sentencing to extend sentences, as opposed to indiscriminately doing so for everyone based on prior records.[1,96]

Abolishing mandatory minimums for low-level nonviolent offenses and drug offenses

There is growing discourse about abolishing mandatory minimums and requiring prosecutors and judges to wrestle with the appropriateness of incarceration in each case, as well as the length of any carceral sentence.[1,98] Experts argue that states can remove all mandatory minimums by reviewing existing statutes and deleting each reference to a set minimum period of incarceration per crime or class of crime and replace it with a more general statement that a judge may sentence someone to incarceration up to the maximum period of incarceration.[1,97]

Creating a "second-look" sentencing review

Second-look laws allow courts to reexamine a sentence after a person has served a period of time—10 to 15 years in most instances —to determine if the sentence still serves its original purpose.[1,99] These laws have increasingly become a viable way to reexamine needlessly long sentences and send people home from prison who can safely return to the community.[1,100] In the 2021 legislative session, second-look bills were introduced in 14 states; three, in Illinois, Maryland, and Oregon, passed.[1,101] The less restrictive versions of these bills allow justice-involved people to petition for relief; more restrictive versions reserve the petition power to district attorneys or the courts.[1,102] Although second-look laws may reduce the number of people currently incarcerated, they can suffer from the same pitfalls as parole boards.[1,101] For example, the California prosecutor-led second-look law that passed in 2019 has thus far resulted in about 100 releases in a state with a daily prison population of nearly 100,000 people.[1,103] The District of Columbia law, along with its later expansion to encompass people who were convicted of offenses that occurred up to age 26, has a better track record, with 67 people released in five years in a jurisdiction that has a daily justice-involved population of around 1,400.[1,104]

Expanding the existing statutory safety valve

Scholars argue that if Congress maintains mandatory minimum sentences, it should limit their use to exceptional cases and expand the statutory "safety valve" provision to allow courts more discretion.[1,105] Currently the safety valve provision permits a sentencing court to disregard a statutory minimum sentence for the benefit of certain low-level, nonviolent, cooperative defendants who have a minimal prior criminal record and were convicted of certain mandatory minimum controlled-substance offenses.[1,106] While the First Step Act of 2018 expanded relief for defendants with slightly more extensive prior criminal records, some have encouraged Congress to permit courts to invoke the safety valve in a broader set of circumstances.[1,107]

CURRENT AMA POLICY

The AMA has extensive policy addressing criminal justice system reform due to the intersections with health. Most relevant to this report is AMA Policy D-430.992 "Reducing the Burden of Incarceration on Public Health" which calls on the AMA to support efforts to reduce the negative health impacts of incarceration, through implementation and incentivization of adequate funding and resources towards indigent defense systems; implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records; and housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings. This policy also calls on the AMA to partner with public health organizations and other interested parties to urge Congress, the Department of Justice, the Department of Health and Human Services, and state officials and agencies to minimize the negative health effects of incarceration by supporting programs that facilitate employment at a living wage, and safe, affordable housing opportunities for formerly individuals who are incarcerated, as well as research into alternatives to incarceration. AMA Policy H-80.993 "Ending Money Bail to Decrease Burden on Lower Income Communities" supports legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes.

AMA Policy H-95.907 "Address Disproportionate Sentencing for Drug Offenses" supports efforts to eliminate this sentencing disparity (from 18:1 to 1:1) and apply them retroactively to those already convicted or sentenced. AMA

Policy H-100.955 "Support for Drug Courts" supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; encourages legislators to establish drug courts at the state and local level in the U.S.; and encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. AMA Policy H-95.899 "Restorative Justice for the Treatment of Substance Use Disorders" acknowledges that inequitable sentencing structures, such as towards crack cocaine versus opioids, have contributed to unjust imprisonments. AMA Policy H-95.901 "Drug Policy Reform" states that the AMA supports elimination of criminal penalties for drug possession for personal use as part of a larger set of related public health and legal reforms designed to improve carefully selected outcomes. Further, AMA Policy H-430.980 "Compassionate Release for Incarcerated Patients" supports policies that facilitate compassionate release for incarcerated patients based on serious medical conditions and advanced age.

CONCLUSIONS

Incarceration in the U.S. rose at an unprecedented rate for nearly four decades beginning in 1973.[108] The initiatives, under the narrative of "tough on crime," involved enacting a range of sentencing policies designed to increase admissions to prison and to lengthen the amount of time served on a felony sentence.[107] Such policies were adopted by the federal government and every state to varying degrees. As a result of these changes, the combined prison and jail population of about 330,000 in 1972 has grown to over 1.9 million today.[109] The goal of mass incarceration was to improve public safety outcomes.[110] Evidence has shown that incarceration has an impact on crime, but the scale of that effect is much more modest than many policymakers or members of the public believe.[108,109] At best, the rise of incarceration may have produced about a quarter of the decline in crime that has occurred since the early 1990s.[111] Other studies have found this effect to be as low as five percent.[1,109,110] The second primary research finding on the effects of incarceration is that there are diminishing returns to public safety.[110] A key factor underlying this conclusion is that lengthy prison terms keep individuals behind bars long after they present a significant risk to public safety.[1,110] Further, incarceration has negative health impacts on those who are incarcerated with studies noting higher rates of infectious diseases, mental health diagnoses, substance use disorders, and overall lower life expectancy.[1,23,110] Birthing people in correctional facilities face even more unique issues such as issues related to breastfeeding, the possibility of being shackled while giving birth, lack of access to prenatal care, as well as the trauma of being separated from their newborns.[1,23,110]

There have also been efforts to address the length of prison terms in both the federal and state systems. At the federal level, the most impactful shift has been the decisions by the U.S. Sentencing Commission to revise drug offense guidelines downward, initially for crack cocaine offenses and subsequently for all drug offenses, and then to apply those revisions retroactively.[1,110] In state corrections systems, approaches to reduce sentence lengths have been relatively modest. While twenty-nine states have adopted reforms to mandatory sentencing procedures since 2000, many of these have been narrow in scope, and as a result the impact of reform may be limited.[112] Half of the states still maintain life sentencing policies of "three strikes and you're out" habitual offender laws, and more than half limit parole consideration (generally until eighty-five percent of a sentence has been served) due to the adoption of "truth in sentencing" laws that apply to many convictions.[113] Experts argue that future reforms are still needed to address mass incarceration, these include, but are not limited to removing prior conviction enhancements, providing for judicial discretion in sentencing, and adequate support systems and services for successful reentry into the community.[1,112] Ongoing research is essential to assess the effects of sentencing reform on individuals who have been incarcerated and public safety.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 215-I-23, and the remainder of this report be filed.

1. Our AMA: (1) recognizes the negative impacts associated with prolonged incarceration, including on the physical and mental health of justice-involved individuals and their families, (2) supports efforts to reduce the reliance on incarceration, particularly for non-violent offenders, with recognition that rehabilitation and successful reentry into the community requires adequate support systems and services, (3) supports a system of continuous review of sentences for individuals who are incarcerated providing the opportunity for those who demonstrate rehabilitation and pose a minimal risk to society to be considered for early release, and (4) supports providing judges with the discretion to help ensure that sentences are fair and fit the crime, while protecting against unjust and inconsistent results. (New HOD Policy)

2. Our AMA supports additional research to assess the effects of sentencing reforms on the health impacts of individuals who have been incarcerated and public safety. (New HOD Policy)
3. That our AMA reaffirm the following policies: D-430.992 "Reducing the Burden of Incarceration on Public Health," H-95.899, "Restorative Justice for the Treatment of Substance Use Disorders;" H-95.901, "Drug Policy Reform," H-80.993, "Ending Money Bail to Decrease Burden on Lower Income Communities" (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than $1,000

APPENDIX I - Successful State Reforms to Mandatory Minimum Sentencing

California's Proposition 47	Proposition 47 which passed in 2014, reclassified several property and drug offenses as misdemeanors and led to retroactively reduced sentences.[114] Within three months, almost 9,000 people had been released from California correctional facilities; within one year, that became 13,000 people. Evaluations of Proposition 47 have shown that it led to an immediate 15 percent decline in total drug arrests and a 20 percent decline in property crime arrests, as well as a reduction in racial disparities in arrest rates.[111] Analyses of Proposition 47 impact on crime rates in California have found that the proposition's passage was not associated with a change in violent crime rates, although larceny theft increased modestly following passage.[111] Proposition 47 also reduced recidivism: two-year rearrest and reconviction rates were significantly lower for people released after serving sentences for Proposition 47 offenses compared to their pre-reform counterparts.[115]
New York's Rockefeller Drug Law Reform	In 2009, the New York State Legislature passed full repeal of New York's Rockefeller Drug law and replaced it with a different statutory structure.[116] This sentencing reform permitted drug treatment and alternative-to-prison programs instead of prison sentences and set shorter sentence lengths for those still permitted to be imprisoned for felony drug convictions.[113] An impact study of these reforms found that in the nine months prior to Rockefeller Drug Law repeal, Black and Latinx people were three times more likely than white people to receive a prison sentence following a felony drug arrest.[117] After the drug law reforms, they were twice as likely as white people to go to prison—a 33 percent reduction in a disparity that researchers concluded could not be explained by factors other than race.[114] A follow-up on both sample groups showed that those sentenced to diversion after the reforms had 43 percent fewer rearrests than those sentenced to incarceration.[114]
Illinois	From 1980 to 1983, Illinois corrections officials released 21,000 incarcerated individuals—or 10 percent of the prison population—to alleviate the state's severe prison overcrowding, brought about in part by a huge increase in prosecutorial staffing and the state's move from indeterminate to determinate sentencing.[118] The largest portion of people released were convicted of burglary (26 percent) and armed robbery (15 percent).[115] The average sentence reduction per person was about 105 days, or 12 percent.[115] For the people released early who did go on to commit crimes, these accounted for less than 1 percent (4,500 arrests) of all recorded arrests for the three-year period covering their releases.[115]

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15. PHYSICIAN ASSISTANTS AND NURSE PRACTITIONER MOVEMENT BETWEEN SPECIALTIES

Informational report; no reference committee hearing.

HOD ACTION: FILED

INTRODUCTION

At the 2024 Annual Meeting, Board of Trustees Report 14 was adopted as amended creating Policy H-35.960, "Physician Assistant and Nurse Practitioner Movement Between Specialties" and the remainder of the report was filed.

1. Our American Medical Association encourages hospitals and other health care entities employing nurse practitioners and physician assistants to ensure that the practitioner's certification aligns with the specialty in which they will practice.
2. Our AMA will continue educating policymakers and lawmakers on the education, training, and certification of nurse practitioners and physician assistants, including the concept of specialty switching.
3. Our AMA will continue to support research into the cost and quality of primary care delivered by nurse practitioners and physician assistants.
4. Our AMA will continue to support research into the distribution and impact of nurse practitioners and physician assistants on primary care in underserved areas.
5. Our AMA will continue to support the expansion of access to physicians in under-resourced areas.

Two additional recommendations from this report were referred for further study:

1. That the American Medical Association (AMA) support workforce research, including surveys by state medical and nursing boards, that specifically focus on gathering information on nurse practitioners and physician assistants practicing in specialty care, their certification(s), alignment of their certification to their specialty, and whether they have switched specialties during their career. (New HOD Policy)
2. That the AMA support research that evaluates the impact of specialty switching by nurse practitioners and physician assistants on the cost and quality of patient care. (New HOD Policy)

This Board of Trustees Informational Report summarizes data on this topic to date and discusses our AMA's ongoing research to fill the remaining gaps in the data. This research will inform our AMA's next steps and will also address the referred items as more information is obtained.

BACKGROUND

Existing data from the American Association of Nurse Practitioners (AANP), American Association of Physician Assistants (AAPA), and National Commission on Certification of Physician Assistants (NCCPA) provide insight into which specialties nurse practitioners and physician assistants are practicing, as well as nurse practitioner and physician assistant certifications, including optional specialty certifications. The AAPA and NCCPA data also provide details on specialty switching by physician assistants.

Nurse Practitioners

The AANP, the largest professional organization and leading advocate for nurse practitioners, conducts an annual workforce survey of nurse practitioners practicing in the United States. Per AANP, 385,000 nurse practitioners are currently licensed in the United States. The AANP nurse practitioner workforce survey was sent to all AANP members and nonmembers in the AANP National NP database, excluding individuals without a valid email address, individuals not currently practicing in the United States, and individuals who opted out of receiving AANP surveys. The final sampling group for the information published in the *2024 Nurse Practitioner Practice Report (Practice Report)* and included in this report represents a sample of 10,275 nurse practitioners. The *Practice Report* includes relevant information on the top clinical areas of focus in which nurse practitioners practice, nurse practitioner certification, and optional specialty certifications that are held by nurse practitioners.

The *Practice Report* shares the top 10 clinical areas in which nurse practitioners practice. These clinical focus areas presumably align with the specialty in which the individual is practicing; however, the type of setting in which the

nurse practitioner practices may vary. Based on this information, 36.8 percent of nurse practitioners are practicing in a primary care specialty, which the *Practice Report* defines as family practice, primary care, internal medicine, geriatrics, and OBGYN women's health.

Table 1. Top 10 clinical focus areas[136]	(percent)
Family practice	16.9
Primary care	9.4
Psychiatry/mental health	5.9
Urgent care	5.8
Cardiology	4.2
Internal medicine	4.2
Geriatrics	3.3
OBGYN women's health	3.0
Oncology/hematology	2.7
Pediatrics/general	2.6

The *Practice Report* also provides information on nurse practitioners by population certification area; the certification obtained following graduation and typically required for state licensure as a nurse practitioner. Population certifications may be obtained from a variety of certifying bodies, such as the American Academy of Nurse Practitioner Certification Board or the American Nurses Credentialing Center. Each certifying body offers their own certification and administers their own examination which are generally aligned with the population foci of the nurse practitioner's training. Certification is typically required for state licensure as a nurse practitioner. Most nurse practitioners are certified as Family Nurse Practitioners (FNP-C or FNP-BC). As some nurse practitioners hold multiple certifications the sum of all percentages in the table below is greater than 100 percent.

Table 2. Nurse Practitioners by population certification area[137]	(percent)
Family	68.7
Adult-gerontology primary care	7.9
Psychiatric/mental health	7.1
Adult	7.0
Adult-gerontology acute care	6.1
Acute care	3.9
Pediatric-primary care	2.9
Women's health	2.0
Gerontology	0.9
Neonatal	0.9
Pediatric-Acute Care	0.7
No certification	0.6

Finally, the *Practice Report* shares the percentage of nurse practitioners with additional specialty practice certifications. Nurse practitioners may pursue optional certification(s) in various specialties/subspecialties after initial certification in their role and population focus, as shown in the previous table. An array of certifying boards issue "specialty" certifications for nurse practitioners—typically these certifications are based on hours of practice experience in a specialty and passage of an exam. Customarily, the certifying boards are specific to nursing and specific to a single specialty. Of note, 92.8 percent of nurse practitioners obtain no optional specialty certification.

Table 3. Nurse practitioners with additional specialty practice certifications[138]	(percent)
Wound care	1.3
Hospice and palliative care	1.3
Emergency	1.1
Oncology	0.9
Diabetes management-advanced	0.7
Addictions advanced practice	0.7
Pediatric-primary care mental health	0.4
Occupational health	0.3

Dermatology	0.3
Orthopaedics	0.3
Nephrology	0.2
Genetics advanced nurse	0.1
School health	0.1
No advanced certifications	92.8

Physician Assistants

The NCCPA, which is the only certifying organization for physician assistants in the United States, conducts similar workforce surveys of physician assistants, including the *Statistical Profile of Board Certified Physician Assistants (General Report)*, and *Statistical Profile of Board Certified Physician Assistants by Specialty (Specialty Report)*.[139,140] The latest NCCPA reports are based on data collected from all physician assistants who are board certified as of December 31, 2023 and have made updates to their profile maintained by NCCPA. Of these physician assistants, 149,909 provided responses for at least a portion of their profile which informed the reports. These reports provide data on physician assistants by their principal clinical specialty, relevant specialty certifications, as well as specialty switching. The *Specialty Report* includes detailed data on the number of physician assistants practicing in 68 specialties. According to the *General Report*, 75.3 percent of physician assistants practice in one of the top 10 specialties, as follows:

Table 4. Physician Assistants by specialty[141]	Number (percent)
Family medicine/general practice	20,940 (16.5)
Other	14,208 (11.2)
Emergency medicine	13,727 (10.8)
Surgery – orthopaedic	13,534 (10.7)
Dermatology	5,449 (4.3)
Internal medicine/general practice	5,073 (4)
Hospital medicine (hospitalist)	4,548 (3.6)
Surgery – general	3,895 (3.1)
Internal medicine – cardiology	3,705 (2.9)
Surgery - cardiothoracic	3,056 (2.4)

The *General Report* analyzes changes in physician assistants' primary practice areas between 2019 and 2023. For example, the *General Report* shows that 18.7 percent of physician assistants practiced in a surgical specialty (e.g., orthopaedic surgery, cardiovascular surgery, and neurosurgery) in 2023.[142] This is the largest practice area for physician assistants and has remained the same since 2019. By contrast, the number of physician assistants practicing in family medicine/general practice has declined from 18.6 percent in 2019 to 16.5 percent in 2023. The number of physician assistants in emergency medicine has also declined slightly from 12.8 percent in 2019 to 10.8 percent in 2023.

The *Specialty Report* includes information on the percentage of board-certified physician assistants who completed a postgraduate program (fellowship or residency) in a specialty, including primary care. The five highest specialties in which physician assistants completed a postgraduate program are: critical care medicine (16.1 percent), emergency medicine (10.4 percent), dermatology (9.0 percent), cardiothoracic and vascular surgery (8.4 percent), and psychiatry (8.1 percent).[143] The *Specialty Report* also highlights the relationship between the postgraduate program and the specialty in which the physician assistant is currently practicing, as shown in the table below. The likelihood of physician assistants practicing in the same specialty in which they completed a postgraduate program varies considerably. For example, of the physician assistants who completed a postgraduate program in emergency medicine, 85.7 percent are currently practicing in emergency medicine, while only 11.1 percent of physician assistants who completed a post graduate program in gerontology are currently practicing in gerontology.[144]

Table 5[145]		
Physician Assistants postgraduate program by specialty practice area	Complete postgraduate program (residency or fellowship) (percent)	Practice area of postgraduate program same as current principal practice area (percent)
Primary care	3.3	47.6
Cardiology	2.9	27.4
Cardiothoracic and vascular surgery	8.4	33.7
Critical care medicine	16.1	69.9
Dermatology	9.0	84.1
Emergency medicine	10.4	85.7
Family medicine/general practice	3.4	44.7
Gastroenterology	2.8	33.3
General surgery	6.7	72.3
Geriatrics	2.9	11.1
Hospital medicine	5.0	65.9
Internal medicine-general practice	2.9	27.6
Neurology	3.7	54.0
Neurosurgery	4.3	27.0
Obstetrics and gynecology	4.1	73.0
Occupational medicine	5.9	21.3
Oncology	3.9	53.1
Orthopaedic surgery	5.0	68.5
Otolaryngology	4.3	40.7
Pain medicine	3.5	15.4
Pediatrics-general	2.9	47.7
Physical medicine/rehabilitation	1.8	23.1
Plastic surgery	6.6	13.0
Psychiatry	8.1	74.4
Urology	3.8	31.4

The *Specialty Report* also elucidates on specialty switching. As part of the data gathering by NCCPA, physician assistants were asked "how many times they changed specialties throughout their career thus far."[146] The rate of those who have not changed specialties varied from a high of 60.3 percent for physician assistants practicing in orthopaedic surgery to a low of 19.2 percent for those practicing in occupational medicine.[147] A separate report by AAPA, *PAs and Specialty Change*, provides some additional data on the preparation, motivation, and timing of specialty switching by physician assistants.[148] Per this report, 20 percent of physician assistants have changed their specialty at some point in their career.[149] Overall physician assistants with less than five years of experience were most likely to change specialties.[150] The report also found that physician assistants who switched specialties once were more likely to switch multiple times. In terms of preparation by physician assistants prior to switching specialties, 79.9 percent stated they prepared through on-the-job training while 77.3 percent identified self-study.[151] Finally, the report examined the type of support physician assistants receive after they have switched specialties, finding that 88 percent of physician assistants who have switched specialties in 2021 received onboarding support for six months or less.[152]

Table 6. Physician Assistants Specialty Switching[153]						
Specialty	Have not changed specialties (percent)	1 time (percent)	2 to 3 times (percent)	4 to 5 times (percent)	6 to 10 times (percent)	Over 10 times (percent)
Primary care	54.0	19.4	20.0	5.1	1.4	0.1
Cardiology	46.3	26.4	22.2	4.0	1.1	<0.1
Cardiothoracic and vascular surgery	52.1	23.4	19.8	3.9	0.8	0.1
Critical care medicine	47.1	24.3	22.6	4.9	1.0	0.1
Dermatology	50.2	26.1	19.2	3.7	0.9	<0.1
Emergency medicine	52.9	22.6	19.6	3.9	1.0	0.1

Family medicine/general practice	56.3	18.4	19.2	4.8	1.3	0.1
Gastroenterology	41.9	27.4	23.8	5.2	1.7	0.1
General surgery	45.8	23.1	23.4	6.0	1.7	0.1
Geriatrics	32.0	22.7	30.2	11.4	3.4	0.4
Hospital medicine	52.2	19.2	21.5	5.7	1.3	<0.1
Internal medicine-general practice	45.3	22.2	23.6	6.9	2.0	0.1
Neurology	42.2	25.5	23.4	7.3	1.4	0.2
Neurosurgery	50.5	20.7	23.4	4.2	1.2	0.0
Obstetrics and gynecology	50.0	23.9	20.0	5.2	0.9	0.1
Occupational medicine	19.2	22.1	36.6	17.0	4.8	0.2
Oncology	44.8	25.6	21.8	6.7	1.1	0.0
Orthopaedic surgery	60.3	19.7	16.2	3.2	0.6	<0.1
Otolaryngology	42.4	27.4	24.0	4.5	1.8	0.0
Pain medicine	29.8	26.9	29.7	10.9	2.7	0.1
Pediatrics-general	52.5	22.6	20.4	3.8	0.6	0.1
Physical medicine/rehabilitation	31.6	23.1	32.9	9.5	2.9	0.0
Plastic surgery	33.9	29.5	27.9	7.4	1.4	0.0
Psychiatry	45.6	23.8	21.1	7.2	2.2	0.1
Urology	46.0	22.0	22.8	7.4	1.7	0.0

DISCUSSION

The AANP, NCCPA, and AAPA reports provide some useful data on nurse practitioner and physician assistant certifications and the specialties in which they practice. For example, the data show that while 68.7 percent of nurse practitioners are certified in primary care, only 36.8 percent practice in primary care. Additionally, a shockingly low number of nurse practitioners receive any optional advanced certifications in specialties, suggesting that most nurse practitioners practicing in specialties have no training in that specialty. Similarly, the NCCPA data shows that only a small percentage of physician assistants receive any specialty specific postgraduate training, yet the majority of physician assistants practice in specialties and over half switch specialties at least once during their career. This also suggests that physician assistants practicing in specialties often have no formal training in that specialty.

CONCLUSION

While the AANP, NCCPA, and AAPA reports provide some useful data, gaps in data remain necessitating additional research to provide a full response to the first two resolves of BOT 14-A-24. To fill these gaps, our AMA has engaged with a trusted vendor to conduct additional research. This research is currently underway and will be shared with the HOD in a subsequent Report at I-25.

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16. RESEARCH CORRECTING POLITICAL MISINFORMATION AND DISINFORMATION ON SCOPE OF PRACTICE

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-405.968, "Research Correcting Political Misinformation and Disinformation on Scope of Practice," which calls for the following:

> That our AMA Board of Trustees perform a comprehensive literature review on current research on correcting political misinformation and disinformation and conduct field research on ways to correct political misinformation and disinformation amongst policymakers as it pertains to scope of practice. (Directive to Take Action)
>
> That our AMA Board of Trustees report its findings and recommendations to the HOD on correcting political misinformation and disinformation and that our AMA incorporate these findings to the extent possible into our AMA's advocacy efforts on scope of practice. (Directive to Take Action)

This report will provide an overview of the current research on correcting political misinformation and disinformation, as well as highlight field research currently underway by our AMA based on learnings from this literature review.

BACKGROUND

The topic of how to correct misinformation and disinformation has garnered much attention over the last decade, particularly as the internet and social media platforms have increased the ability for misinformation and disinformation to spread.[1] Misinformation and disinformation can occur across various disciplines such as health, the environment, politics, and crime[2] and can include "inaccurate news, conspiracy theories, disinformation campaigns, propaganda, and slanted reporting."[3] Misinformation can be created and spread by individuals, organizations, government entities, politicians, corporations, and/or the media.[4] In contrast to disinformation, there does not need to be mal-intent or even intent to mislead for something to qualify as misinformation. Indeed, misinformation can even arise unintentionally, such as through reporting on evolving events like natural disasters where information changes as the event unfolds and new information becomes available.[5] The scientific process also lends itself to refinement over time, "this piecemeal approach to knowledge construction is the very essence of the scientific process, through which isolated initial findings are sometimes refuted or found not to be replicable."[6]

For the purposes of this report, the Board of Trustees has been asked to focus its research on how best to correct political misinformation and disinformation. It is important to understand that the leading scholars on this issue caution that the issue is complex and there is no one-size fits all solution.[7] The ability to correct misinformation may depend on a variety of factors, such as the credibility of the source of information, whether the information aligns with one's

personal beliefs, and whether the information aligns with one's social and political identities.[8] That said, studies do reveal some techniques that have shown promise in effectively correcting misinformation. In November 2023, the American Psychological Association published a Consensus Statement entitled, *Using Psychological Science to Understand and Fight Health Misinformation* (*APA Consensus Statement*). The *APA Consensus Statement* describes the body of research on the psychology of misinformation, noting that experts remain divided on many key issues, including "how to define misinformation clearly, how to quantify how many people are regularly exposed to it, what factors make people susceptible to believing and hearing it online and offline, and how best to counter the problem at scale."[9]

Defining Misinformation and Disinformation

There is not a commonly agreed upon definition for misinformation or disinformation. The *APA Consensus Statement* defines misinformation as "any information that is demonstrably false or otherwise misleading, regardless of its source or intention"[10] and goes on to distinguish between misinformation and disinformation, specifying that disinformation involves an explicit intent to deceive or manipulate others. The *APA Consensus Statement* elected to focus on the broader term of misinformation, noting the difficulty in proving motive, and thus the challenge in distinguishing between misinformation and disinformation.[11]

Other scholars in this area have offered the following definitions:

- Misinformation occurs when false information is shared, but no harm is meant;
- Disinformation occurs when false information is knowingly shared to cause harm; and
- Malinformation occurs when "genuine information is shared to cause harm, often by moving information designed to stay private into the public sphere."[12] Malinformation has also been defined as information that stems from the truth but is exaggerated in a way that misleads and causes potential harm.[13]

Theories for Correcting Misinformation

Much of the literature on corrective techniques focuses on misinformation not disinformation or malinformation. Misinformation corrective techniques may focus on correcting specific messages or teaching individuals how to spot manipulation techniques and stop the spread of misinformation.

The *APA Consensus Statement* describes the following four corrective techniques found in literature on this topic:

1. Debunking or fact-checking;
2. Inoculation theory or prebunking;
3. Literacy interventions; and
4. Nudging.

A separate meta-analysis comparing the effectiveness of techniques used to correct misinformation across science, health, politics, marketing, and crime focuses on the following common corrective techniques. These techniques overlap with those in the *APA Consensus Statement* as noted below:

1. Appeals to consensus (similar to nudging);
2. Coherence (part of the corrective technique in debunking);
3. Source credibility (similar to literacy interventions);
4. Fact-checking (similar to debunking); and
5. Providing general warnings (similar to inoculation).

<u>Debunking or Fact-Checking</u>

Debunking or fact-checking is a common corrective technique used to state the inaccuracy of information, why it is incorrect, and often followed-up with the correct information. Unlike the inoculation or prebunking technique, which will be discussed below, this technique is used after misinformation has already been shared. Fact-checking is commonly used during political debates either in real-time or post-debate.

In general, studies have found that debunking alone is ineffective. One reason cited is because individuals tend to follow conversational norms and assume that speakers are truthful. Individuals may also continue to believe

misinformation despite attempts to fact-check due to the "continued influence effect," in which misinformation retains its perceived truth despite attempts to correct.[14] In other words, fact-checking does not fully remove the false information from one's memory and familiarity with a message – even if it is incorrect – can increase its perceived truth. For example, one study found that debunking misinformation rarely eliminated one's reliance on misinformation, reducing references by only about 50 percent.[15] Studies also point to the importance of the tone of the correction, noting that authoritative retractions can be especially ineffective and may lead individuals to further entrench in the misinformation. The use of negative emotions in the correction has also been studied. For example, one study examining the use of emotions in corrective techniques related to tobacco found that the use of negative emotions was more effective than a simple correction; however, authors of the study caution that their findings are limited to the controlled setting in which they were examined and cannot be generalized.[16]

Research has found that the effectiveness of debunking increases when paired with other corrective methods, such as following up with correct information. According to several researchers, refuting the misinformation and replacing it with correct information has proven effective because it maintains the coherence of the story.[17] Indeed, leaving gaps in a narrative can limit the effectiveness of a corrective technique. Similarly, simple explanations are preferred over complex explanations.[18]

Inoculation Theory or Prebunking

Inoculation theory was originally developed by McGuire in the 1960s as a strategy to prevent misinformation from influencing individuals by building an individual's resistance to persuasion. Unlike fact-checking, inoculation or prebunking occurs before an individual receives the misinformation. The idea is to inoculate an individual by providing them with a weakened form of the misinformation, share why it is inaccurate, and provide clues on how one might be able to spot it in the future.[19] The theory has evolved to include both inoculating against specific messages and providing general mechanisms or forewarnings on how to spot common manipulation tactics.[20] Using inoculation techniques for specific issues typically involves two parts (1) identifying the threat, and (2) refutational preemption (prebunking). The threat component includes a warning that an individual will hear a specific piece of misinformation plus a less convincing version of the falsehood. This warning is then followed up with a refutational preemption or prebunking, i.e., the correct information.[21] Noting the challenges with prebunking every piece of misinformation, researchers have turned to using inoculation to inform individuals on how to spot common manipulations techniques used to spread misinformation. These are often gamified and include platforms like "Bad News," (https://www.getbadnews.com/en) a role-playing game that teaches users manipulation techniques and awards them points for crafting a misinformation campaign that attracts followers, with the intent to make them better informed and able to spot misinformation in their daily lives.[22] Truth Labs for Education (https://inoculation.science/inoculation-videos/), is another example. Truth Labs for Education is a collaboration between Cambridge University, the University of Bristol, and Google Jigsaw that also has a series of videos aimed at inoculating individuals against common manipulation techniques used to spread misinformation. Similarly, Google has a series of videos (https://prebunking.withgoogle.com/) aimed at helping individuals spot manipulation techniques and providing guidance on how to successfully prebunk misinformation. Notably, there is overlap with these inoculation techniques and the literacy interventions and nudging techniques described below.

Inoculation has proven an effective technique in preempting the effect of misinformation. For example, one study found that inoculation of specific messages on climate change proved effective.[23] Researchers have also found that corrective actions including both a forewarning and preemptive refutation (prebunking) of the misinformation was most effective.[24] Since it would be nearly impossible to perform inoculation against each and every falsehood, studies have also measured the scalability of inoculation techniques across issues. The findings are promising. For example, studies have found that an individual who has been inoculated against one falsehood is less likely to be susceptible to misinformation in other contexts.[25] Similarly, a systemic review and meta-analysis confirmed this phenomenon finding that inoculation is "effective in creating more resistant attitudes against misinformation while improving truth discernment."[26] Studies have also found that inoculation can have long term effects – up to a week – and up to three months with brief reminders ("booster shots") of the inoculation.

Researchers, however, note that there are limitations with inoculation, including that most studies on the effectiveness of inoculation are done in controlled environments with only a few studies examining its effectiveness in correcting real-world misinformation.[27] In addition, most studies in this body of research focus on the effectiveness of inoculation techniques in improving the identification of misinformation. More research is needed on the effectiveness of inoculation in replacing misinformation with accurate information.

Literacy Interventions

Literacy intervention techniques are focused on improving an individual's ability to discern the accuracy of information and spot misinformation. As mentioned above, this technique often incorporates inoculation theories. The *APA Consensus Statement* describes this technique in terms of health literacy, media literacy, and digital literacy. Health literacy includes informing individuals how to evaluate health content for quality or accuracy. Media literacy includes the ability to evaluate the quality of print and online media and digital literacy includes the ability to properly execute tasks online.[28] These interventions often occur in formal settings, including schools, universities, and community centers.

In terms of the effectiveness of these approaches, the *APA Consensus Statement* describes mixed results, noting that there may be some short-term benefits, but that interventions may require a significant investment of time and resources (e.g., interventions lasting more than five hours were more likely to be effective than those lasting one hour).[29] In addition, the report notes that few studies have focused on or shown a lasting effect of literacy interventions, challenging their long term impact.[30]

Nudging

Unlike the techniques described above, which are often focused on correcting misinformation, nudging is a technique used to encourage behavioral changes in individuals, such as encouraging them to correctly identify misinformation. Anti-misinformation nudges may include accuracy nudges, social-norm nudges, and motivational nudges.[31] Accuracy nudges encourage people to reflect on the importance of only sharing accurate information with others. Per the *APA Consensus Statement*, "social-norm nudges are geared toward news-sharing behavior and emphasize either injunctive norms (i.e., behaviors most people find acceptable or not) or descriptive norms about it (i.e., how other people respond in certain situations)."[32] Finally, motivational nudges "seek to motivate people to be as accurate as possible (e.g., paying them to correctly identify true and false news)."[33]

In general nudging is a systems-based technique aimed at correcting one's behavior rather than a technique used to correct misinformation related to specific topics or specific messages. For example, X and TikTok have, at times, integrated nudging techniques into their platform to encourage users to examine the veracity of the information and re-consider whether it should be shared with others.[34] Some have suggested that when inoculation is combined with nudging, the effectiveness of both techniques increases.[35]

In terms of the effectiveness of nudging, a meta-analysis described in the *APA Consensus Statement* "found that accuracy nudges were effective overall at improving sharing discernment, although this effect was both small and heterogeneous."[36] Similarly, a field study on X, when it was known as Twitter, found that social norm nudges were effective in improving the identification of misinformation.[37] Finally, motivational nudges, including paying people to correctly identify misinformation, were also found effective in both improving people's ability to accurately identify misinformation and reducing any partisan bias when reviewing information.

However, researchers also note mixed findings on studies of the effectiveness of nudging, as well as some general limitations. Notably, there is concern that effectiveness may be short-lived and wear off after several repetitions.[38] Nudging may also be less effective toward individuals who do not want to be nudged.[39]

DISCUSSION

The body of literature on techniques to correct political misinformation and disinformation provides guidance which may be applicable to correct myths often used by those supporting inappropriate scope of practice expansions. As noted in the literature, however, correction of political misinformation poses unique challenges, as research consistently shows people are more resistant to changing political beliefs compared to other domains. This resistance appears particularly strong among educated political partisans, suggesting that corrective techniques relying solely on increased education or providing additional information on a topic may be insufficient. This may be particularly true among legislators. Indeed, researchers have noted that an individual's worldview or ideology can play a key role in one's susceptibility to misinformation and the effectiveness of corrective techniques. Correcting political misinformation may also be faced with suspicion due to perceived motivations behind the misinformation and those correcting the misinformation.

Scholars have also shared limitations in this body of research. For example, much of the research has been done in a controlled setting, therefore, these techniques may not have the same level of effectiveness when replicated in a real-world environment. Finally, these theories are often tested on specific age groups or the general population, not policymakers or lawmakers, making it difficult to know whether these techniques will prove effective for this audience.

This literature review has been instrumental in providing the basis for our next step: assessing the effectiveness of these techniques to counter arguments related to scope of practice expansions. This step is currently underway and includes our AMA engaging in field research to test these techniques on specific messages often used by those supporting scope of practice expansions. Our AMA will incorporate findings from this field research into our scope of practice advocacy campaign. The cost necessary to implement Policy D-405.968, "Research Correcting Political Misinformation and Disinformation on Scope of Practice" including conducting the field research has already been approved and allocated by our AMA. With the directives having been accomplished, the Board of Trustees recommends rescinding this policy.

RECOMMENDATION

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

> That our American Medical Association rescind Policy D-405.968, "Research Correcting Political Misinformation and Disinformation on Scope of Practice."

Fiscal Note: Less than $500.

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17. ANTIDISCRIMINATION PROTECTIONS FOR LGBTQ+ YOUTH IN FOSTER CARE

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

BACKGROUND

During the 2024 Annual Meeting, the House of Delegates (HOD) Resolve 2 of Resolution 224-A-2-24 titled, Antidiscrimination Protections for LGBTQ+ Youth in Foster Care was referred for report.[1] The resolve recommended:

> RESOLVED, that our AMA support efforts by the Department of Health and Human Services and other appropriate stakeholders to establish a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data in the Foster Care Analysis and Reporting System only when strong privacy protections exist.

Resolution 224-A-24 received mixed reviews when it was up for discussion in Reference Committee B. Testimony reflected that most LGBTQ+ groups believe that this data should be collected by the federal government "to enhance

recruitment of foster homes, promote visibility for marginalized groups, help to analyze youth outcomes, and address disparities."[2] However, there were serious concerns related to data privacy and overall child safety.[3] Additional testimony highlighted the divide between which governmental body should collect SOGI data for LGBTQ+ youth, federal or state and local governments.[4]

DISCUSSION

The foster care system in the United States serves as a critical safety net for children and youth who are unable to remain in their homes due to abuse, neglect, or other family challenges. Administered at the state level with federal oversight and funding, the system provides temporary care and placement, aiming to ensure the safety, well-being, and permanency of children. (Permanency "is a permanent, stable living situation, ideally one in which family connections are preserved.")[5] While the foster care system supports over 390,000 children annually, it faces significant challenges, including a shortage of foster families, disparities in outcomes for children of color and LGBTQ+ youth, and barriers to achieving permanency through reunification or adoption.[6]

LGBTQ+ youth, particularly transgender individuals, are significantly overrepresented in the foster care system, with approximately 30 percent identifying as LGBTQ+ and five percent as transgender—far exceeding their representation in the general population.[7] These youth face heightened risks of discrimination, mental health challenges, and disrupted placements due to systemic biases and lack of affirming care. Collecting sexual orientation and gender identity (SOGI) data in the foster care system would be a critical step toward improving such outcomes for LGBTQ+ youth.[8]

The U.S. Department of Health and Human Services (HHS) plays a central role in guiding and supporting efforts to collect SOGI data in child welfare. Within HHS, the Administration for Children and Families (ACF) oversees the Adoption and Foster Care Analysis and Reporting System (AFCARS), a national data system that tracks case-level information on children in foster care. Historically, AFCARS has not required the reporting of SOGI information.

However, recognizing the significant need for better data to serve LGBTQ+ youth, HHS and partnering agencies would make great strides in improving health outcomes by establishing a reporting mechanism for anonymized, aggregated SOGI data in AFCARS. These efforts would involve multiple interested parties – federal and state child welfare agencies, advocacy organizations, former foster youth, and experts in data collection and privacy – collaborating to design policies and practices that encourage SOGI data reporting.

A paramount concern in collecting SOGI information is ensuring strong privacy protections. Given the sensitive nature of sexual orientation and gender identity data, inappropriate disclosure can put youth at risk of stigma, discrimination, or even harm (for instance, some foster youth have been "outed" without consent, resulting in hostile reactions from caregivers).[9] Physicians and other healthcare professionals who care for foster youth understand the importance of confidentiality in maintaining trust; similarly, confidentiality is crucial when youth share SOGI information. The goal, therefore, is to develop data systems that yield valuable insights into LGBTQ+ foster youth's needs and the effectiveness of supportive interventions while rigorously safeguarding individual privacy. Federal guidance emphasizes that SOGI data collection must only proceed with measures to secure privacy, security, and civil rights – including robust consent practices and restrictions on data use.[10] This report underscores the need for the establishment of a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data into AFCARS and overview of privacy protections considerations.

Unstable Policy Landscape around Collection of Data among LGBTQ+ Communities

In recent years, the policy landscape has evolved to explicitly support the inclusion of SOGI data in foster care reporting. In 2016, under the Obama Administration, HHS's ACF issued a groundbreaking final rule to update AFCARS after over two decades; this rule would have, for the first time, required state child welfare agencies to collect and report SOGI-related data.[11] The 2016 rule specified that youth ages 14 and older would be asked to voluntarily self-report their sexual orientation, and that agencies would report the sexual orientation of foster/adoptive parents and legal guardians, as well as whether a youth's entry into care involved family conflict related to SOGI. The ACF explained that these data points were intended to "better support children and youth in foster care who identify as LGBTQ+" by ensuring placement resources and services could be tailored to their needs. This policy marked a significant recognition at the federal level that SOGI data are integral to child welfare planning.

However, the implementation of the 2016 AFCARS SOGI data requirements was halted and reversed under the first Trump administration. The rule's effective date was delayed multiple times in 2017–2018, and by 2019 HHS proposed rescinding the SOGI elements, citing a desire to reduce reporting burden and concerns that sexual orientation data were "too sensitive and private" for a government record.[12] In May 2020, a final rule was issued that eliminated the collection of sexual orientation data from AFCARS entirely.[13] This rollback was met with strong opposition from advocacy groups and some state officials, who argued that removing SOGI data "is a huge mistake that will harm the children we serve," making LGBTQ+ youth and their outcomes "invisible" in national statistics.[14] Massachusetts youth advocates responded by urging their state to collect and report SOGI data on its own, condemning the federal withdrawal as an "abandonment" of responsibility to LGBTQ foster youth.[15] The policy back and forth between 2016 and 2020 highlighted that, absent federal requirements, efforts to gather SOGI data would rely on state-level initiative or future policy changes.

The pendulum continues to swing regarding SOGI data collection. In June 2022, President Biden issued Executive Order 14075 on Advancing Equality for LGBTQI+ Individuals, which explicitly directs federal agencies to improve SOGI data collection while safeguarding privacy.[16] This order led to the creation of a Federal Evidence Agenda on LGBTQI+ Equity and an HHS-led SOGI Data Action Plan in 2023.[17,18] The HHS SOGI Data Action Plan calls on the entire department to enhance the health and well-being of all Americans by systematically collecting SOGI data in its programs, "whenever data on other demographic characteristics are collected."[19] In practice, this means HHS operating divisions and staff divisions would be reviewing their data systems (including those for foster care) to add SOGI variables where feasible.[20] The plan urges updating binary gender categories to be more inclusive and ensuring that SOGI questions would be incorporated into demographic data collection as soon as possible.[21] This renewed policy emphasis from HHS leadership signaled strong support for establishing a SOGI reporting mechanism in AFCARS. Additionally, various states and localities have enacted their own policies to gather SOGI data in social services – for example, California implemented a SOGI data collection law that added SOGI fields to statewide client databases – further building momentum for broader adoption.[22] However, in January 2025, President Trump rescinded Executive Order 14075 and other key policies aimed at protecting LGBTQ+ individuals, reversing federal efforts to collect SOGI data in foster care, health care, and other social services while also limiting anti-discrimination protections across multiple agencies.[23,24]

Benefits of Collecting SOGI Data in Foster Care

Collecting SOGI data within AFCARS stands to yield significant benefits for the well-being of children and adolescents in foster care, particularly those who are LGBTQ+. One of the clearest benefits is the ability to identify and address health inequities and needs more accurately. LGBTQ+ youth in care face distinctive health challenges – for example, higher rates of depression, suicidal ideation, and trauma related to identity-based rejection.[25] If child welfare and health care professionals know how many individuals are affected and can correlate that with health outcomes, they can better allocate mental health services, counseling, and support programs. For instance, if data reveal that a substantial percentage of foster youth identify as transgender, agencies can ensure there are clinicians trained in gender-affirming care available for consultations. Similarly, if lesbian, gay, or bisexual youth in care show higher utilization of emergency mental health services, that could prompt focused preventive interventions (such as support groups or mentoring programs to build resilience). In short, what gets measured gets addressed – by capturing SOGI information, the foster care system can move from anecdotal awareness of LGBTQ+ youths' struggles to quantitative evidence that spurs more efficient and effective health care planning and resource allocation.[26,27]

From a social services perspective, SOGI data helps ensure that policies and practices are inclusive. For example, knowing the proportion of youth identifying as LGBTQ+ can inform recruitment of foster families.[28] Agencies might invest more in recruiting affirming foster homes or training existing foster parents on LGBTQ+ issues if data show a high need. Essentially, SOGI data allows for a more individualized approach in a system that often has to take broad steps to address various challenges.

Physicians who work with foster children (e.g., pediatricians in foster care clinics, child psychiatrists) would see direct benefits too. Providing affirming sexual health counseling would benefit all of their patients, and could help close gaps for foster children, particularly those who identify as LGBTQ+. If a physician is aware that a patient is part of a population at elevated risk for certain issues, they can institute procedures and/or create systems that prompt focused screening and intervention. For example, a primary care doctor knowing their foster patient is LGBTQ+ might increase their frequency of screening for depression or anxiety. On a systemic level, health care professionals can partner with child welfare to develop trauma-informed, LGBTQ+-affirming care models when the need is documented.[29]

Furthermore, data might reveal positive outcomes where supportive policies are in place, thereby guiding best practices that health care professionals can advocate for, and health systems can scale up.

Finally, at a human level, asking SOGI questions in a respectful manner can itself send a message of inclusion to youth of all identities. Many LGBTQ+ youth in particular report feeling invisible or misunderstood in systems of care. When a caseworker or health care professional asks about their identity in a validating way and that information is used to support them, it affirms to the young person that they are seen and valued. This can build trust in the system. Over time, as data-driven improvements take root, one would hope to see tangible benefits: reductions in homelessness among LGBTQ+ youth who have aged out of the foster care system, fewer incidences of bullying or abuse in placements, better mental health status, and more stable, affirming placements – all of which contribute to healthier outcomes.

Privacy Protections for SOGI Data in Foster Care

Privacy laws are a critical component that ensure sensitive information is protected. Any state that receives a grant under the Child Abuse Prevention and Treatment Act (CAPTA), "must provide an assurance that it has in effect and is enforcing a state law that includes methods to preserve the confidentiality of all child abuse and neglect reports and records in order to protect the rights of the child and the child's parents or guardians, including requirements to ensure that the information is released only to certain individuals and entities."[30,31]

While foster care agencies are not considered "covered entities" under the Health Insurance Portability and Accountability Act (HIPAA), the principles of health information privacy are highly relevant to the collection of SOGI data. SOGI data can be considered sensitive, similar to health information, and should be safeguarded accordingly. Under HIPAA, any individually identifiable health information, including SOGI data in medical or counseling records must be protected and disclosed only for permitted purposes.[32] In April 2024, HHS reinforced these protections, preventing disclosure of health data for investigations related to gender-affirming care, further underscoring the expectation of privacy for SOGI-related information.[33]

Since AFCARS is an administrative database rather than a public health repository, any SOGI data collected would be subject to federal confidentiality rules, which also means federal laws such as the Privacy Act of 1974 applies to AFCARS data, requiring a System of Records Notice outlining its collection and use and restricting disclosure without consent. When properly anonymized and aggregated, SOGI data falls outside the scope of personally identifiable information and is not subject to HIPAA or Privacy Act restrictions. However, the initial collection of SOGI data—when attached to a youth's case—must be carefully managed under strict confidentiality rules.

Federal and State Legal Protections

In recent years, several federal directives have specifically addressed SOGI data privacy. Executive Order 14075, which as mentioned above was rescinded in early 2025, instructed agencies to safeguard privacy, ensure informed consent, and limit the use of SOGI information.[34] The Trump administration also rescinded the March 2021 Department of Justice (DOJ) memo providing that DOJ would apply the Supreme Court's holding in *Bostock v. Clayton County*[35] (that Title VII of the Civil Rights Act of 1964 protects employees against discrimination and unjust termination based on their sexual orientation or gender identity) in the context of Title IX and, accordingly, Section 1557, weakening protections.

However, federal civil rights laws including Title VI of the Civil Rights Act continue to prohibit discrimination based on sex, which includes sexual orientation and gender identity; reinforcing the notion that SOGI data should be used to prevent disparities, not perpetuate discrimination.

State laws also impact SOGI data collection in foster care. Child welfare information, including SOGI details, is generally protected under state confidentiality statutes, limiting access to authorized parties such as case workers and health care professionals.[36] Some states have taken proactive steps to affirm LGBTQ+ youth rights. For instance, California's Foster Youth Bill of Rights (AB 175) ensures that youth are referred to by their preferred name and gender pronouns.[37] Additionally, California's AB 959 mandates SOGI data collection across state programs, leading to its inclusion in child welfare databases like Child Welfare Services/Case Management System.[38]

However, some states have enacted laws hostile to LGBTQ+ rights, such as bans on gender-affirming care or restrictions on discussing LGBTQ+ issues in schools.[39] In such states, there are concerns that SOGI data could be misused. While foster care data is not public, legal safeguards must ensure that access to SOGI data remains restricted

and not subject to improper demands. No lawful basis currently exists for law enforcement or other agencies to access SOGI data from child welfare records simply to enforce anti-LGBTQ policies. To ensure both the protection of sensitive information and the effectiveness of data collection, it is crucial to establish a secure and standardized approach.

SOGI data collection at the federal level ensures consistency, comparability, and comprehensive national oversight. Federal agencies like the CDC and HHS generally have the infrastructure, resources, and reach necessary to gather or support standardized data across states, which is essential for identifying disparities and informing equitable public health and policy interventions. While state and local governments can complement these efforts with localized data collection, relying solely on them could risk inconsistency and incomplete data due to varying political climates and resource limitations. A federal framework with assistance to state and local governments and clear guidelines and privacy protections would strike a balance, ensuring LGBTQ+ populations are accurately represented and better served nationwide.

Addressing Privacy Concerns

Despite safeguards, privacy risks remain. A primary concern is the unintended disclosure of a youth's LGBTQ+ status, which can lead to stigma, discrimination, or even removal from supportive placements. Reports from the Government Accountability Office highlight cases where case workers or foster parents inappropriately disclosed a youth's SOGI information, leading to harm.[40] Additionally, in politically charged environments, concerns persist that SOGI data could be accessed for punitive purposes, similar to efforts in some states to obtain medical records related to gender-affirming care.[41]

To mitigate these risks, agencies must uphold strict need-to-know access policies, ensuring SOGI data is only accessible to those directly involved in the individual's care. Courts typically receive only information relevant to a proceeding, and SOGI data should not be included unless necessary. HHS has committed to publishing only anonymized and aggregated SOGI data, ensuring no individual can be identified.

Individual consent remains a fundamental protection. The scrapped 2016 AFCARS rule framed SOGI questions as voluntary for youth age 14 and older, a principle likely to carry forward in future implementation. Research suggests that youth are more likely to disclose SOGI information when assured of confidentiality.[42] Agencies can further enhance privacy by requiring explicit consent before sharing SOGI data with third parties, such as foster parents.[43]

From a security perspective, child welfare information technology systems already incorporate firewalls, encrypted databases, and role-based access to restrict data visibility.[44] Confidentiality agreements and mandatory staff training on LGBTQ+ cultural appropriateness reinforce ethical data handling.[45,46]

Challenges and Considerations

Implementing SOGI data collection in foster care could present several challenges that should be addressed.

Resistance and Pushback: Some interested parties, including state and local officials, argue that sexual orientation and gender identity are private matters and question their relevance to child welfare.[47] Others cite concerns about workforce burden, including training, software updates, and data entry.[48] Political opposition has also hindered progress, with some fearing that collecting SOGI data may be misinterpreted as encouraging LGBTQ+ identification.[49] Additionally, religious objections from foster agencies and parents further complicate data collection efforts.[50,51]

Ethical and Community Concerns: The voluntary nature of SOGI disclosure is crucial, as individuals in foster care may not yet feel comfortable identifying or may fear repercussions. LGBTQ+ advocacy groups generally support data collection for visibility and service improvements, but concerns about misuse persist. Another concern is if SOGI data is improperly accessed, LGBTQ+ youth in foster care could become targets for discrimination, harassment, or punitive actions, particularly in states with anti-LGBTQ+ policies. Given the vulnerability of foster youth, unauthorized disclosure of their SOGI status could lead to unsafe placements, rejection by caregivers, or even legal repercussions in hostile jurisdictions, underscoring the critical need for strict privacy protections. Agencies must engage youth, community members, and organizations most impacted to ensure ethical data practices and accountability. Furthermore, collecting this data creates an obligation to use it effectively, rather than letting it sit unused.

Balancing Data Collection with Privacy: Protecting individual privacy is a top priority. Agencies must implement strict safeguards, ensuring that only authorized personnel access SOGI information. Training caseworkers on appropriate, sensitive questioning and confidentiality protocols is essential to prevent accidental disclosures or misuse. Agencies should also monitor for breaches and adjust policies as needed.

Resource and Operational Considerations: States differ in technical capacity, and under-resourced agencies may struggle to integrate new data fields. If HHS reinstates SOGI data requirements, funding and technical support will be needed. Ensuring accuracy is also a challenge, as incorrect data entry or assumptions by caseworkers could lead to harm. Systems should allow self-reporting and updates to reflect evolving identities.

Changing Political Winds: The collection of SOGI data has been subject to policy reversals, with one administration requiring it and another rescinding it. These shifts create uncertainty for states and child welfare workers. Establishing bipartisan professional consensus, supported by organizations like the American Academy of Pediatrics and the Child Welfare League of America, can help normalize SOGI data collection as a standard child welfare practice rather than a political issue.

To navigate these challenges, transparency is key. Agencies must clearly communicate why they are collecting SOGI data, how it will be used, and the protections in place. Engaging people and organizations most impacted, addressing concerns proactively, and demonstrating the benefits—such as improved services—can help build trust. For health care professionals, these challenges mirror the initial resistance to collecting other sensitive health data, underscoring the importance of careful implementation, privacy protections, and long-term commitment to better care for LGBTQ+ foster youth.

Current AMA policy

The AMA has adopted several policies to support LGBTQ+ individuals in health care, foster care, and legal protections. Below is a summary of these policies.

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation (H-315.967)

- Supports the voluntary inclusion of biological sex, gender identity, sexual orientation, and related data in medical records in a culturally sensitive way.
- Advocates for standardized data collection in medical research to improve patient care.
- Calls for collaboration with health IT vendors to ensure equitable treatment of patients regardless of gender identity.
- Supports the use of personal health records to reduce administrative burden.
- Urges the incorporation of best practices into electronic health records at no additional cost to physicians.

Protecting the Integrity of Public Health Data Collection (H-440.817)

- Advocates for the inclusion of sexual orientation and gender identity (SOGI) data in national and state health surveys, registries, and surveillance systems.
- Opposes the removal of SOGI data from such databases without a plan for updating demographic measures.

Medical Spectrum of Gender (D-295.312)

- Works to educate the medical community and the public on the diversity of gender identities.
- Supports policies that ensure access to quality healthcare for gender-diverse individuals.
- Affirms that an individual's gender, sex, and sexual orientation may not always align, recognizing gender identity as distinct from sex assigned at birth.

Opposing Mandated Reporting of People Who Question Their Gender Identity (H-65.959)

- Opposes laws requiring disclosure of patient information related to gender identity, gender dysphoria, intersex identity, or gender transition, including for minors.

Support of Human Rights and Freedom (H-65.965)

- Supports the dignity, equal rights, and non-discrimination of all individuals, including those of diverse gender identities and sexual orientations.
- Opposes hate crimes and advocates for legal protections against discrimination.

Encouraging LGBTQ+ Representation in Medicine (D-200.972)

- Advocates for targeted recruitment of LGBTQ+ students in medical education.
- Supports including SOGI data in demographic surveys to assess representation in medicine.
- Works with medical organizations to better understand and address the unique experiences of LGBTQ+ individuals in healthcare professions.

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations (D-65.996)

- Encourages physicians to display a nondiscrimination policy in medical offices affirming inclusivity for all patients.

Nondiscrimination Policy (H-65.983)

- Affirms that the AMA does not and has never discriminated based on sexual orientation or gender identity.

LGBTQ+ Older Adults (D-65.979)

- Promotes awareness of aging-related LGBTQ+ health issues among the public, healthcare professionals, and policymakers.
- Supports cultural competency training for clinicians caring for LGBTQ+ older adults.
- Advocates for inclusive healthcare policies and practices in all settings.
- Calls for increased funding for research on LGBTQ+ aging and health disparities.

Health Care Needs of LGBTQ+ Populations (H-160.991)

- Encourages nonjudgmental recognition of LGBTQ+ identities in medical care.
- Supports physician education on LGBTQ+ health needs at all levels, from medical school to continuing education.
- Opposes conversion therapy.
- Collaborates with organizations to enhance physician competency in LGBTQ+ healthcare, including screening for conditions such as STIs and intimate partner violence.
- Promotes partnerships with LGBTQ+ communities to improve medical understanding and care.

Antidiscrimination Protections for LGBTQ+ Youth in Foster Care (H-60.895)

- Supports federal and state policies that protect LGBTQ+ youth from discrimination in the foster care system.
- Advocates for training child welfare professionals and foster caregivers to create safe and affirming placements.
- Promotes efforts to reduce violence against LGBTQ+ youth in foster care.
- Encourages recruitment of LGBTQ+-affirming foster families.
- Supports placing gender-diverse youth in homes that respect their identities.

Equal Access for Adoption in the LGBTQ+ Community (D-60.964)

- Advocates for equal adoption rights for LGBTQ+ individuals meeting federal criteria.
- Encourages government funding for child welfare agencies that provide inclusive adoption services.

Reducing Suicide Risk Among LGBTQ+ Youth (H-60.927)

- Partners with public and private organizations to reduce suicide rates and improve mental health for LGBTQ+ youth.

Promotion of LGBTQ+ Friendly and Gender-Neutral Intake Forms (D-315.974)

- Supports the development and implementation of inclusive medical documentation and forms to ensure accurate patient data collection.

Endorsing LGBTQ+ Research IRB Training (D-460.966)

- Advocates for standardized Institutional Review Board (IRB) training on research involving LGBTQ+ populations.

Nondiscrimination in Healthcare (H-65.976)

- Encourages medical institutions to include sexual orientation and gender identity in nondiscrimination policies for patients, employees, and healthcare workers.

Preventing Anti-Transgender Violence (H-65.957)

- Calls for increased public education on hate crimes against transgender individuals, particularly Black transgender women.
- Advocates for law enforcement data collection on transgender hate crimes and improved reporting.
- Supports stronger policies to prevent bias in law enforcement interactions with transgender individuals.
- Promotes increased access to mental health care and resources for LGBTQ+ individuals.

Youth and Young Adult Suicide Prevention (H-60.937)

- Recognizes youth suicide as a serious health crisis.
- Supports physician education on suicide prevention, screening, and intervention.
- Advocates for increased mental health resources, research, and targeted programs for high-risk populations, including LGBTQ+ youth.
- Calls for public awareness and policy action to address youth mental health crises, particularly post-COVID-19.

Conclusion

Integrating SOGI data into AFCARS is a critical step toward a more equitable child welfare system. This report highlights the importance of collecting SOGI data with strong privacy protections to improve policies, practices, and health outcomes for LGBTQ+ youth, who are overrepresented in foster care yet remain largely invisible in national data. While some federal protections have gone away, other protections like HIPAA, the Privacy Act, and confidentiality laws ensure privacy safeguards, while modern technology enables secure and anonymized data collection.

Establishing a secure and anonymized SOGI data reporting system aligns foster care systems with broader public health goals, advancing health equity for LGBTQ+ youth. With careful implementation, this initiative can build trust, ensure safer placements, and improve long-term outcomes. Achieving these goals requires ongoing collaboration among HHS, child welfare agencies, health care professionals, and the youth themselves. Supporting SOGI data collection while upholding the highest privacy standards, would be a vital step toward a more inclusive, responsive foster care system—one that truly serves and protects all children.

RECOMMENDATION

The Board therefore recommends that Resolve 2 of Resolution 224-A-24 be adopted and the remainder of the report be filed:

1. That our AMA support efforts by the Department of Health and Human Services and other appropriate stakeholders to establish a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data in the Adoption and Foster Care Analysis and Reporting System only when strong privacy protections exist. (New HOD Policy)

Fiscal Note: To be determined.

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18. PHYSICIAN ASSISTED SUICIDE

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOD ACTION: **RECOMMENDATIONS ADOPTED**
REMAINDER OF REPORT FILED
See Policy H-140.819

At the 2023 Interim Meeting, the House of Delegates (HOD) referred Resolution 004, "Study of Physician Assisted Suicide and Medical Aid in Dying," which was introduced by the Medical Student Section. This resolution asked our American Medical Association (AMA) to:

> Oppose criminalization of physicians and health professionals who engage in medical aid in dying at a patient's request and with their informed consent, and oppose civil or criminal legal action against patients who engage or attempt to engage in medical aid in dying
>
> Use the term "medical aid in dying" instead of the term "physician assisted suicide" and accordingly amend HOD policies and directives, excluding Code of Medical Ethics opinions

Rescind our HOD policies on physician assisted suicide, H-270.965 "Physician Assisted Suicide" and H-140.952 "Physician Assisted Suicide," while retaining our Code of Medical Ethics opinion on this issue

Amend H-140.966 "Decisions Near the End of Life" by deletion as follows, while retaining our Code of Medical Ethics opinions on these issues:

Our AMA believes that:

(1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

(3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.

~~(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.~~

(5) Our AMA supports continued research into and education concerning pain management

Study changing our existing position on medical aid in dying, including reviewing government data, health services research, and clinical practices in domestic and international jurisdictions where it is legal

BACKGROUND

Physician assisted suicide occurs when "a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform a life-ending act" [1]. This act is sometimes referred to using other terminology such as medical aid in dying. Currently, there is no federal law governing physician assisted suicide; therefore, individual states are permitted to determine their own legal stance. At this time, 10 states and the District of Columbia permit this practice; however, most states have legislation banning this practice [2]. Furthermore, two states have removed their residency requirement, effectively opening the practice of physician assisted suicide more broadly to patients throughout the US.

Our AMA has a long-standing policy (H-270.965) opposing the legalization of physician assisted suicide. That said, our AMA is also opposed to the criminalization of physician medical judgement and the regulation of medical practice through criminal penalties (H-160.954, D-160.911, D-275.944, H-5.980, D-5.999). Additionally, our AMA has policy preserving a physician's right to exercise their autonomy (H-405.958, *Code of Medical Ethics* Opinion 1.1.7).

DISCUSSION

The referred resolution addresses several issues encompassed within the broad context of physician-assisted suicide: terminology, opposition to the legalization and practice of physician assisted suicide, and opposition to the criminalization of physician participation in assisted suicide. This report addresses these topics in the context of our AMA's current HOD policies and Code of Medical Ethics guidance. In addition, the Council on Ethical and Judicial Affairs has produced two informational reports to further discuss the ethical complexity of these topics as they relate to physician assisted suicide and the practice of medicine.

Terminology

The terminology used in the AMA Code of Medical Ethics and HOD policy to describe this practice offers a clear delineation of intent and action. The use of other terminology to describe this practice has the potential to confuse patients and unduly influence decision making [5]. Descriptors such as Medical Aid in Dying (MAID), physician aid-in-dying, and death with dignity could apply to palliative care practices and compassionate care near the end of life that do not include intending the death of patients. In CEJA Report 2-A-19, "Physician Assisted Suicide," the Council determined that PAS was the terminology which described the practice best. The report supported this supposition with the following analysis which remains valid:

> The Council recognizes that choosing one term of art over others can carry multiple, and not always intended messages. However, in the absence of a perfect option, CEJA believes ethical deliberation and debate is best served by using plainly descriptive language. In the Council's view, despite its negative connotations, the term "physician assisted suicide" describes the practice with the greatest precision. Most importantly, it clearly distinguishes the practice from euthanasia. The terms "aid in dying" or "death with dignity" could be used to describe either euthanasia or palliative/hospice care at the end of life and this degree of ambiguity is unacceptable for providing ethical guidance.

Opposition to the legalization and practice of physician assisted suicide

AMA policy opposes the legalization and practice of physician assisted suicide stating that it is "fundamentally incompatible with the physician's role as a healer" [1]. In developing CEJA Report 2 (A-19) which informed our AMA's current ethics standards on physician assisted suicide, the Council on Ethical and Judicial Affairs analysis and deliberations were informed by available data and research. However, its decision was not an empirically dictated one, but rather, it was driven by the core values of medicine preserved within the Code of Medical Ethics.

Although legislative developments since 2019 have occurred, recent empirical data reviewing physician assisted suicide practices in US and international jurisdictions where PAS and/or euthanasia are legal are subject to varied interpretations. As a matter of ethical reasoning, the data does not settle the ethical issue. Additionally, the relevant core ethical values at stake have not changed since the adoption of CEJA Report 2 (A-19). As such, the AMA's position on physician assisted suicide should remain unchanged.

Of note, the AMA's position on physician assisted suicide is not a position of neutrality and establishes that the profession of medicine should not support the legalization or practice of physician assisted suicide or see it as part of a physician's role.

Opposition to the criminalization of physician participation in assisted suicide

While AMA policy opposes the legalization of or participation in physician assisted suicide, this stance must also be balanced with AMA policies opposing criminalization of physician medical judgement within the confines of the law and the use of criminal penalties to regulate medical practice. As a physician's choice to engage in the practice of physician assisted suicide is considered by many to be a medical judgement, failing to oppose criminalization of physicians who engage in physician assisted suicide may be contrary to the AMA's long-standing opposition to interference with physician medical judgement. To wit, the AMA's recognition that physicians may have differing aspects of conscience is upheld in the *Code of Medical Ethics,* which states that "morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician assisted suicide." Additionally, the *Code* Appendix to the opinion on physician assisted suicide notes that the AMA *Code* preserves the opportunity for individual physicians "to act (or refrain from acting) in accordance with the dictates of conscience in their professional practice." [2]. In essence, if after due moral consideration, a physician decides to participate in the practice, they will be judged to have acted conscientiously, consistent with the AMA *Code* [3].

If after due moral consideration, a physician exercises their autonomy, conscience, and medical judgement to participate in physician assisted suicide, our AMA should uphold its long-standing opposition to the criminalization of physician medical judgement and the imposition of criminal penalties on medical practice. Opposing criminalization of physicians who engage in physician assisted suicide, while simultaneously not supporting the legalization of this practice, will allow our AMA to uphold its existing core values including not supporting the legalization of the practice of physician assisted suicide (H-270.965, *Code of Medical Ethics* Opinion 5.7), opposing criminalization of physician medical judgement and health care decisions (H-160.954, D-160.911, D-275.944, H-5.980, D-5.999, D-160.999), and allowing physicians to uphold their conscience (H-405.958, *Code of Medical Ethics* Opinion 1.1.7).

It is important to distinguish between opposing the legalization of physician assisted suicide and opposing the criminalization of physicians who engage in the practice within the confines of the law in the jurisdiction in which they practice as an exercise of their medical judgement. Opposing legalization refers to our AMA organizational stance against the *practice* of physician assisted suicide, whereas criminalization refers to our AMA organizational stance regarding the *consequences* to physicians for engaging in the practice of physician assisted suicide. Additionally, criminalization is different from a civil penalty in that criminalization has a potential consequence of incarceration, whereas a civil penalty only carries a financial consequence.

Additionally, in keeping with AMA policy of protecting the patient-physician relationship, including protecting patients who engage in shared-medical decision making with their physician and patient exercise of autonomous medical decision making and information consent (H-165.837, *Code* 2.1.1, and 1.1.3), it follows that our AMA should oppose the criminalization of patients engaging or attempting to engage in physician assisted suicide at their request, with their informed consent.

CONCLUSION

While AMA policy opposes legalization of physician assisted suicide, it also upholds the principles that medical judgement should not be subject to criminal penalties and remains committed to protecting the integrity of the patient-physician relationship.

RECOMMENDATIONS

The Board of Trustees recommends adoption of the following in lieu of the Resolution 004-I-23, "Study of Physician Assisted Suicide and Medical Aid in Dying" and the remainder of this report be filed:

Our American Medical Association opposes:

(1) Civil or criminal legal action against physicians and health professionals who legally engage in physician assisted suicide at a patient's request and with their informed consent.
(2) Civil or criminal legal action against patients who engage or attempt to engage in physician assisted suicide.

Fiscal Note: Minimal – Less than $500

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19. USING PERSONAL AND BIOLOGICAL DATA TO ENHANCE PROFESSIONAL WELLBEING AND REDUCE BURNOUT

Reference committee hearing; see report of Reference Committee G.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

INTRODUCTION

At the 2024 Annual Meeting of the House of Delegates (HOD), Policy D-460.962, "Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout," introduced by the Integrated Physician Practice Section, was adopted. This report addresses the first directive of this policy which asked that our American Medical Association (AMA) "monitor and report on the research regarding technology, measures, and effective use of

personal and biological data to assess professional workforce wellbeing and inform organizational interventions to mitigates burnout" (Directive to Take Action). A separate report has been developed that addresses the second directive of this policy.

BACKGROUND:

Physician burnout

Physician burnout is defined as "emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness" and impacts all physicians.[1] The dangers of physician burnout are significant and widespread, resulting in adverse outcomes not only for physicians—such as broken relationships, problematic alcohol use, and suicidal ideation[2]—but also for patients and the health care system at large. For instance, physician burnout has been shown to result in increased medical errors and malpractice suits[3–5], and physicians reducing their clinical hours or leaving the profession altogether.[6–12] Compared to other U.S. workers, physicians work longer hours and experience worse work-life integration.[2] Burnout is also associated with higher health care expenditures.[13–15]

Many factors, both at the system and practice level, can contribute to burnout, including high physician task load[16], poor work-life integration[17], administrative burdens related to electronic health records (EHRs)[15,18–24], and regulatory burden.[25–27] A lack of work control[28] and being unable to take vacation or having to work while on vacation also are associated with increased risk of burnout[29]. Additionally, the politicization of medical care[30] and childcare stress[31] during the COVID-19 pandemic have been associated with burnout.

Measuring burnout and wellbeing

Physician burnout is commonly measured using validated survey instruments. One of these surveys is the Maslach Burnout Inventory-Human Services Survey (MBI-HSS), a 22-question instrument released in 1981 that's considered the "gold standard" for assessing burnout.[32,33] The survey covers three areas—emotional exhaustion, depersonalization, and a low sense of personal accomplishment. Responses to questions covering these areas are rated by frequency: never, a few times a year or less, once a month or less, weekly, a few times a week, or daily. Researchers typically consider respondents to present at least one symptom of burnout if they have high scores on either the emotional exhaustion or depersonalization subscales.[33]

Developed for use in physicians and non-physician providers, the Mini-Z survey is a ten-question tool adapted from the Minimizing Error Maximizing Outcome clinician survey.[34,35] It was designed to assess workplace satisfaction, stress, and burnout. Additionally, it captures factors including work control, value alignment with organizational leadership, teamwork, documentation time pressure, and EHR use. The Mini-Z single item burnout measure has demonstrated good correlation with the MBI-HSS emotional exhaustion subscale[34] and thus, when researchers are solely interested in this subscale, they may use a single-item burnout measure like that from the Mini-Z to reduce survey length and increase response rates.[36] Since its development, it has been adapted for use in nurses, residents, medical students, and others.[35]

The Mini-Z tool is an essential part of the Organizational Biopsy®, an assessment tool offered by the AMA that measures the drivers of burnout and wellbeing at health systems and large practices.[37] The tool provides a comprehensive evaluation across four domains: organizational culture, practice efficiency, self-care, and retention.[38] It includes standardized questions on leadership, team culture, efficiency, and individual wellbeing. It also has demographic questions to aid health systems in identifying vulnerable populations in need of greater support, as well as customizable questions to gain insights into organization-specific concerns.[37]

As single-item burnout measures have been critiqued for providing an incomplete view of physician wellbeing, researchers from Stanford developed and validated the Stanford Professional Fulfillment Index—a comprehensive tool that captures key aspects of professional fulfillment, including satisfaction, engagement, happiness, and meaningfulness.[39] The instrument is a 16-question survey designed for physicians. It measures three areas: professional fulfillment, work exhaustion, and interpersonal disengagement using a five-point Likert scale. Higher professional fulfillment scores indicate greater wellbeing, while higher work exhaustion and interpersonal disengagement scores reflect greater burnout.[33]

The Patient-Reported Outcomes Measurement Information System (PROMIS) is a set of person-centered measures assessing physical, mental, and social health in both the general population and those with chronic conditions. It was designed to enhance clinician-patient communication across diverse research and clinical settings.[40] Although PROMIS has been widely used to measure patient outcomes, some studies have utilized PROMIS measures to evaluate aspects of physician health, including sleep-related impairment and mental health. For instance, one study used PROMIS to examine the relationship between sleep-related impairment and occupational wellness indicators such as work exhaustion, interpersonal disengagement, overall burnout, and professional fulfillment.[41]

In addition to surveys, factors that contribute to physician burnout have also been measured using EHR user audit log data[20,42,43], and through qualitative methods such as interviews[44–46] and focus groups[47,48]

Biometrics

"Biometrics" has emerged as another way of studying burnout and factors that contribute to it. It is the science of using measurable characteristics—often categorized into physiological or behavioral traits—to describe individuals.[49] It provides objective indicators of stress through sensors such as patient monitors or wearable devices that capture physiological changes associated with sympathetic nervous system activity (e.g., heart rate, respiratory rate, finger prints, retinal vessel patterns, and skin temperature).[49,50]

Until recently, studies aimed at measuring physiologic data to track and develop interventions designed to mitigate stress were conducted in a laboratory with participants attached to bulky cable monitor apparatuses to collect biometric data or via self-reported studies. Such methods made the study of live conditions challenging.[49,51] Wrist-worn wearable devices (e.g., the Fitbit) originally marketed to consumers to improve fitness[49] are beginning to be used in research to collect biometric data from study participants, determine associations with stress and burnout, and identify targeted interventions. Recent innovations in wearable technology enable unobtrusive, real-time monitoring of physiological metrics related to wellbeing.[50,51]

A substantial body of literature focuses on the use of biometric data to identify stress and wellbeing in the general population. This research highlights the potential of biometric feedback for promoting self-awareness and positive behavior change, as well as innovative solutions (e.g., smartwatches and machine learning algorithms) for continuous, real-time health monitoring. For example, Ortoleva et al. (2024) found that physical data representations enhanced self-reflection and mental health intentions in university students. Participants' heart rate (HR) data was collected via EEG Muse headbands and Fitbit watches.[52] Khayyat et al. (2024) analyzed streams of physiological and behavioral data to develop a highly accurate machine learning model for monitoring psycho-physiological stress among employees.[53] Matsumoto et al. (2022) also constructed a machine learning model that aimed to improve stress prediction in older adults by correlating daily activities with biometric data. The approach increased prediction accuracy by over ten percent compared to baseline data, highlighting the potential to improve health management, quality of life, and overall wellbeing for older adults through proactive and innovative solutions.[54]

The following literature review outlines research on the use of biometrics to study wellbeing among physicians specifically.

DISCUSSION

Literature review

Objective

The purpose of this review was to evaluate and understand the current state of research on biometric data to assess physician wellbeing and inform organizational interventions to mitigate burnout.

Methods

The literature review was conducted in the Google Scholar, PubMed, and Medline databases. Studies published between the years of 2015 and 2025 were included. The studies included consisted of U.S.-based studies that used and reported biometric data to study professional wellbeing and included physicians as study participants. In Google Scholar and PubMed, "biometrics physician well-being" and then "biometrics physician stress" were first searched but did not yield studies aligned with inclusion criteria. Studies that met the inclusion criteria were identified in the

three databases when the search terms were changed. The terms, “study of clinician burnout with biometrics”, “biometrics physician well-being”, and “biometrics physician stress”, were searched in Google Scholar. The term, “biometrics physician stress”, was searched in PubMed, and “physician stress AND biometrics” was searched in Medline. A total of 13 studies were originally identified and a duplicate included from both PubMed and Medline was removed. After the titles and abstracts of the remaining 12 studies were screened, one study was excluded since it was not U.S.-based. Next, the full text of the remaining 11 articles were screened and two were removed since they did not report biometric data. In the end, nine studies were eligible to be included in the review. Figure 1 summarizes this process and can be found in the appendix of this report.

Study Characteristics

Of the nine studies included in the review, the most common type of article was a prospective study, with six studies falling into this category. There were two mixed-methods studies, one of which was a live observational usability study and the other a simulation-based study. The remaining study was a scoping review. Eight of the papers were peer-reviewed journal articles, while one was a preprint. The year of publication ranged from 2018-2024, most of which were published within the last five years.

Regarding study samples, all but one study exclusively included physicians—attendings, trainees, residents, fellows, and faculty—while the remaining study also included nurses and medical students. Specialties and practice settings represented among the studies included neurology, emergency medicine (adult and pediatrics), surgery, primary care, and academic medicine.

Seven of the studies used a wearable device—either wrist-worn or a smart shirt—to measure biometric data, while the remaining two used a wearable eye tracking device and a patient monitor in which physicians were affixed to during surgery and had a blood pressure (BP) cuff, pulse oximeter probe, and nasal cannula placed onto them. The most common biometric data collected were heart-related, including heart rate variation (HRV), heart rate (HR), BP, and rate pressure product. Only one study in the review did not collect and/or report these biometrics. Sleep-related biometrics were also collected (e.g., sleep status level and total nightly sleep time), in addition to respiratory-related biometrics (e.g., oxygen saturation, end-tidal carbon dioxide, and respiratory rate). Physical activity and movement-related biometrics that were collected were strain, workout strain, total workouts per 24-hour period, and accelerometry. Other biometrics that were measured involved the skin (skin temperature and electrodermal activity), hormones (hair cortisol level), and eyes (gaze location/fixation and pupil dilation). Figure 2 in the appendix summarizes the characteristics of the nine studies included in this review.

Three major themes were identified in the studies. The first theme was the use of biometric data to identify physiological biomarkers of physician stress and burnout. The second theme was the assessment of the feasibility of using wearable devices to study wellbeing and identify limitations. The final theme to be addressed in this review is the importance of accounting for practice-specific factors as potential confounders when using wearables to study physician wellbeing.

Theme 1: Use of Biometric Data to Identify Physiological Biomarkers of Physician Stress & Burnout

Six studies, Barac et al. (2024), Kaczor et al. (2020), Ciraulo et al. (2022), Slamon et al. (2018), Wolfe et al. (2022), and Akbar et al. (2021), sought to identify physiological biomarkers of physician stress and/or burnout using biometric data. Barac et al. broadly focused on health care professionals (physicians, medical students, and nurses), while the other four studies were specialty-specific (emergency medicine and surgery). Barac et al., a scoping review, included ten papers and did not find any reliable associations between physiological measures derived from wearable wrist-worn devices and clinician burnout. However, the scoping review did identify associations between step count and time in bed with depression symptoms, and heart-related biometrics (HR and HRV) with acute stress.[55]

Kaczor et al. aimed to determine whether physiological biomarkers of stress among physicians during their clinical work could detect stress in the emergency medicine setting. All participants successfully wore a wearable sensor for nine clinical shifts over the course of six months. Findings showed that wearable sensors detected stress 20 minutes before individuals self-reported stress. This suggests the possibility of either delayed reporting or delayed stress awareness among physicians, and highlights an opportunity for interventions that support early detection of stress to improve wellbeing.[50]

Similarly, Slamon et al. measured HR and HRV of pediatric critical care physicians during live pediatric intensive care unit scenarios including patient rounds, tracheal intubation, and central line insertion. Compared to physicians' baseline biometric data, tracheal intubation and central line insertion activities resulted in higher levels of sympathetic activation.[49]

Wolfe et al. placed pediatric critical care fellows and faculty in simulated high and low stress roles to examine the relationship between subjective and objective stress measures. Subjective stress was measured via a self-reported anxiety assessment and objective stress was measured via HRV obtained from a wearable device. Significant differences in self-reported, subjective measurements and wearable-obtained, objective stress measurements were observed between low- and high-stress roles, as demonstrated by a strong correlation between HRV markers and anxiety levels.[56]

Additionally, Ciraulo et al. showed that surgeons experienced statistically significant increases in HR, BP, and cellular metabolism while performing operations, shedding light on the potential long-term risks resulting from continuous triggering of sympathetic activation (e.g., heart disease) by job-specific stress.[57]

Finally, Akbar et al. examined the relationship between EHR inbox work patterns and primary care physician physiologic stress. Physicians wore devices that measured HRV for seven days. On average, physicians spent 1.08 hours on inbox work of which patient messages consumed the most time. Findings revealed three periods in which physiological stress were shown to increase: in the first hour of work, early afternoon, and evening. Physicians tending to inbox work after hours experienced the longest average stress duration during work hours, as they were more likely to batch emails, spending more time per message, compared to those who managed their inbox during work hours (e.g., between patient appointments), thus spending less time per message.[51]

Theme 2: Assessing the Feasibility of the Use of Wearable Devices to Study Wellbeing & Identification of Limitations

The literature review also explored the feasibility and limitations of using wearable devices to study physician wellbeing. Niotis et al. (2021) and Kaczor et al. (2020) supported this high feasibility. In Kaczor et al., all emergency medicine physician participants successfully wore the wrist-worn sensors during their shifts. Only a five percent incidence of failure to fully capture data was experienced.[50] Niotis et al. used a wearable device to assess exercise and sleep among neurology residents and examine associations with validated survey measures. The majority of study participants (68.8 percent) were deemed "consecutive wearers" of the wrist-worn device. However, this study only found moderate-to-low correlations between physiological measures and survey responses. Additionally, barriers to wearing the device included participants forgetting and not being motivated.[58]

Barac et al., Akbar et al., and Slamon et al. detailed limitations in using wearable devices to study physician wellbeing. The scoping review by Barac et al. identified methodological issues including short durations of observing participants while wearing the devices which restrict the capture of real-world variations in workplace stressors. Additionally, a lack of systematic use of validated instruments to measure burnout, anxiety, and depression was noted.[55] In the Akbar et al. study, wearable device data for five primary care physicians was lost due to technical issues. Further, the study attempted to control for impacts on HRV measures by removing periods of physical activity recorded by the device. However, a carry-over effect of physical activity may have still been present in sedentary movements. Moreover, by removing periods of physical activity, the ability to capture stress may have been limited. For example, in the scenario of a stressed physician walking to a meeting, their stress would not have been captured due to it coinciding with physical activity, underscoring the need for innovative methods for biometric studies on burnout that account for factors such as exercise that elevate physiologic markers independently of burnout. Additionally, losing contact with the skin during physical activity was a barrier to the collection of biometric data in this study.[51] Slamon et al. also experienced technical difficulties in their use of a smart shirt device. Reliable readings were limited when the smart shirt wasn't worn tight enough to the skin or its elastic straps weren't worn. The study also had a small sample size.[49]

Theme 3: Accounting for Practice-Specific Factors as Confounders When Using Wearables to Study Physician Wellbeing

Many studies highlighted the need to account for practice-specific factors as potential confounders when using wearables to examine physician wellbeing. Cowart et al. (2022), Niotis et al., Ciraulo et al., and Akbar et al. focused

on anesthesiology, neurology, surgery, and primary care settings, respectively, while Khairat et al. (2019), Kaczor et al., Slamon et al., and Wolfe et al. focused on the emergency medicine environment.

Barac et al. called attention to the multitude of factors—such as workplace stressors, job demand, patient acuity, shift length, and the availability of support staff—that vary by practice setting. As such, practice setting also impacts burnout biomarkers derived from wearable devices. The study suggested that future research "consider collecting organizational variables to better understand the systemic contributors of burnout".[55] Akbar et al. noted that inbox patterns vary between settings and organizations[51], and Slamon et al. identified plans to compare HRV data between different specialties.[49]

CONCLUSION

Current literature provides only a small amount of research focused on physicians and the health care workforce that uses biometric and personal data to measure wellbeing factors such as burnout. The reviewed literature on the use of personal and biological data to assess physician wellbeing focuses on three major themes: (1) the use of biometric data to identify physiological biomarkers of physician stress and burnout; (2) the assessment of the feasibility of using wearable devices to study wellbeing and identify limitations; and (3) the importance of accounting for practice-specific factors as potential confounders when using wearables to study physician wellbeing. The studies reviewed show variation in the utility of the tools studied and limitations that may restrict the feasibility of broad-scale or long-term use in measurement across larger populations.

Limitations of the studies included in the review included inconsistent wearing of the devices, technical challenges and inappropriate use regarding devices which restricted data collection, short observation periods, and a lack of systematic use of validated burnout, depression, and anxiety measures.

Future research should incorporate organization- and practice-specific variables to gain deeper insights into factors that contribute to physician burnout. Biometric data provides crucial knowledge for organizational leadership and clinical practice regarding the short- and long-term impacts of work-related stressors on physician health. For instance, Ciraulo et al. discussed that increased physiological demands over time could lead to future cardiovascular and cerebrovascular issues for physicians. Such research included in this review presents the opportunity for early detection of burnout and the identification of prevention strategies.

AMA POLICY

The AMA has several policies regarding the development and use of metrics to study physician wellbeing.

Our AMA will research and develop useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment in a manner accessible to physicians, with report back to the House of Delegates no later than Annual 2026 (Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems").

AMA policy also directs it to study current tools and develop metrics to measure physician professional satisfaction (Policy D-405.985, "Physician Satisfaction").

Additionally, the AMA recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician wellbeing, particularly for this population of physicians (Policy H-405.948, "Factors Causing Burnout").

RECOMMENDATIONS

The Board of Trustees recommends that the first directive of Policy D-460.962 be rescinded having been accomplished by this report and that the remainder of the report be filed.

Fiscal Note: Modest

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APPENDIX

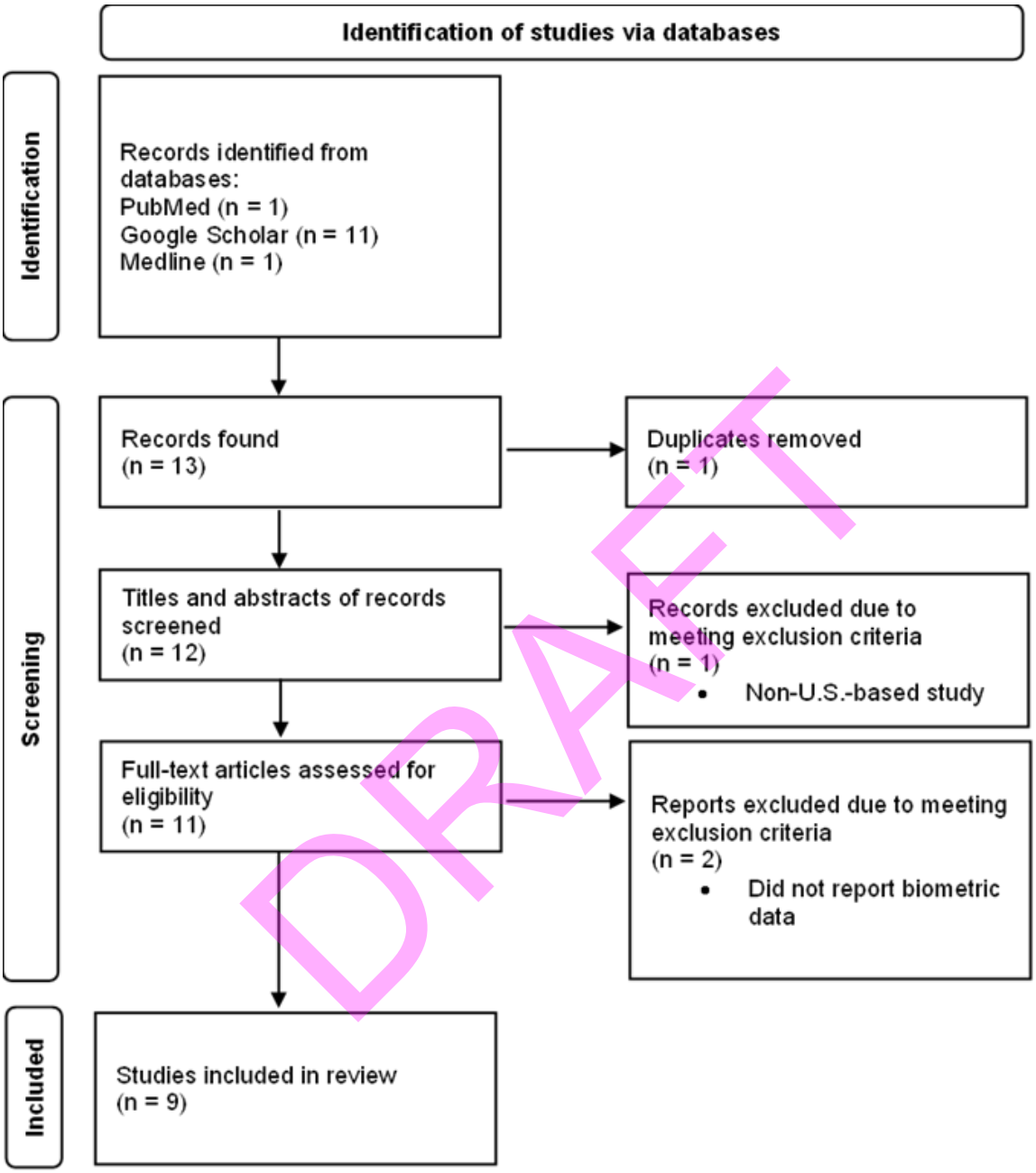

Figure 1: *PRISMA* flow diagram depicting literature review that yielded 9 studies.

Study	Slamon et al. (2018)	Khairat et al. (2019)	Niotis et al. (2020)	Kaczor et al. (2020)	Ciraulo et al. (2020)
Study Type	Prospective	Mixed-methods, live observational usability	Prospective	Prospective	Prospective
Objectives	To measure the biometrics of critical care physicians during clinical scenarios	To propose a framework for understanding EHR-related information overload by identifying areas of poor usability and clinician frustration	To evaluate a wearable biosensor's feasibility in characterizing exercise and sleep in neurology residents, its relationship to validated survey measures, its impact on well-being, and barriers to use	To characterize digital biomarkers of stress among emergency medicine physicians using a wearable sensor	To quantify the physiological impact of surgery on acute care surgeons
Sample	Pediatric critical care attendings/ fellows	Intensive care unit physicians	Neurology residents	Emergency medicine physicians	Surgeons
Biometric Data Collection Device	Hexoskin biometric smart shirt	Tobii Pro Glasses	WHOOP Strap	Empatica E4 wristband	Philips IntelliVue MP5 Patient Monitor
Biometrics Measured	HR, respiratory rate, and HRV	Pupil dilation and gaze location/fixation	Resting heart rate, HRV, strain, exercise frequency/ intensity, and total nightly sleep time	Accelerometry, electrodermal activity, skin temperature, and HR	BP, HR, rate pressure product, oxygen saturation, and end-tidal carbon dioxide
Primary Findings	Critical care activities requiring technical skills led to greater sympathetic activation, with significant increases in mean and maximum heart rate during central venous catheter or	Residents completed tasks more quickly than attending physicians; poor usability, complex interface screens, and navigation difficulties significantly correlated with high frustration levels; and more error messages were associated with longer completion times	Consecutive wearers had significantly higher baseline HRV, HR strain, and workout strain, while nonconsecutive wearers had longer total nightly sleep time. The data supported the feasibility of using these devices as a wellness	Wearable sensor data collected 20 minutes prior to a self-reported stress episode was indicative of stress, suggesting that wearable sensors can detect stress before it is reported or recognized by the individual.	Statistically significant differences were found between baseline data and maximum recordings during surgery for BP, HR, oxygen saturation, and end tidal carbon dioxide, suggesting potential long-term cardiovascular and

	breathing tube insertion in pediatric patients. Researchers found no statistically significant difference in stress levels between tracheal intubation and central line insertion.	due to increased temporal demand.	intervention for select resident groups.		cerebrovascular consequences due to increased physiological demand.

Study	**Akbar et al. (2021)**	**Cowart et al. (2021)**	**Wolfe et al. (2022)**	**Barac et al. (2024)**
Study Type	Prospective	Prospective	Mixed methods, simulation-based	Scoping review
Objectives	To collect EHR use and physiological stress data via unobtrusive means, identify EHR inbox work patterns, and evaluate their association with physicians' stress	To demonstrate the biophysical and psychological benefits of incorporating a mindfulness-based stress reduction program into an urban anesthesiology residency curriculum	To quantify stress differences between low- and high-stress roles and assess the impact of trainee preparedness and self-efficacy on stress levels	To identify physiological burnout biomarkers and highlight current gaps in using wearable technologies to predict burnout among health care professionals
Sample	Primary care physicians	Anesthesiology residents	Pediatric critical care fellows and faculty	Physicians, residents, medical students, and nurses
Biometric Data Collection Device	Garmin Vivosmart wrist-worn device	FitBit	Hexoskin biometric smart shirt	HealthPatch and FitBit
Biometrics Measured	HRV	Hair cortisol level, sleep status level, exercise, and HRV	HRV	HR, HRV, resting HR, respiratory rate, skin temperature, sleep, step count, and activity levels from a work shift
Primary Findings	Physiological stress patterns across the three groups increased during the first hour of work, early afternoon, and evening, with Group 1	Depersonalization scores were significantly lower in the intervention group. Clinical anesthesia residents in PGY-3 had significantly higher emotional	Significant changes in subjective and objective stress measurements were observed between low- and high-stress roles. Two HRV	The studies found no relationship between wearable physiological data and burnout or anxiety, and a short observation duration was a major limitation.

	physicians experiencing the longest stress duration during work hours. Factors such as inbox work duration, EHR window switching rate, and the proportion of inbox work done outside of work hours were independently associated with daily stress duration.	exhaustion and depersonalization scores than PGY-2 residents, with no significant differences in biophysical outcomes between cohorts.	markers were significantly correlated with State-Trait Anxiety Inventory levels. Participants who felt more confident discussing code status experienced a notable decrease in stress during both observer and hot seat roles.	

Figure 2: Summary of nine studies inc

20. GUARDIANSHIP AND CONSERVATORSHIP REFORM

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies H-140.815 and H-140.845

At the 2024 Annual Meeting, the House of Delegates referred Resolution 402-A-24 for a report back at the 2025 Annual Meeting. Resolution 402-A-24 states:

> RESOLVED, that our American Medical Association support federal and state efforts to collect anonymized data on guardianships and conservatorships to assess the effects on medical decision making and rates of abuse (New HOD Policy); and be it further
>
> RESOLVED, that our AMA study the impact of less restrictive alternatives to guardianships and conservatorships including supported decision making on medical decision making, health outcomes, and quality of life. (Directive to Take Action)

BACKGROUND

According to the U.S. Department of Justice, "guardianship should be a last resort because it removes the individual's legal rights and restricts the person's independence and self-determination.[1]" Less restrictive alternatives to guardianships include supported decision-making, delegating health care decision-making to a person chosen by the individual in advance (advance directives), delegating financial decision-making to a person named in advance (financial power of attorney; trust), and a court order authorizing a specific action (such as a health care consent), instead of appointing a guardian whose authority continues over time.[2] Additionally, medical proxies, living wills, and protective arrangements as specified in the Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act (the "Uniform Guardianship Act") are terms for other less restrictive alternatives to guardianships in the health care setting.[3]

Due in part to high-profile celebrity cases that illustrate the significant barriers to modifying or overturning a guardianship, there is a nationwide push towards guardianship reform and less restrictive alternatives to guardianships which place more decision-making powers in the hands of the individual or the protected person. In 2022, the Fourth National Guardianship Summit adopted the Uniform Guardianship Act and its provisions regarding less restrictive alternatives and training on alternatives for judges, lawyers and other interested parties.[4]

The Uniform Guardianship Act provides evidence-based procedures and best practices for guardian appointments. However, the Uniform Guardianship Act has not been adopted by all 50 states. A majority of states require courts to consider whether guardianship is necessary, whether the respondent's needs or interests could be protected by less restrictive means, or both.

Though all 50 states and the District of Columbia have laws regarding guardianship and conservatorship,[5] the legal framework and terminology vary from state to state. Even the scope of a guardianship may vary, with some guardianships focused only on the individual's personal interests and others focused on the individual's property interests (e.g., financial assets). Some address both aspects.

Requirements for proving that a guardianship is absolutely necessary vary among the 50 states, with the highest level of proof being "beyond a reasonable doubt.[6]" This is the least used standard, with only New Hampshire applying this standard.[7] Most states apply a "clear and convincing evidence" standard, which is lower than the "beyond a reasonable doubt" standard but higher than the "preponderance of the evidence" standard, the lowest of the three.[8] To add to the complexity, some states apply a different standard to overturn or rescind a guardianship than the standard that was used to establish the guardianship.[9]

The decision-making standards for guardians also vary among the states. Most states use the "substitute judgment" standard which requires the guardian to substitute the protected person's values and desires for their own to make decisions about the protected person, and by extension, to discern the protected person's personal values and wishes.[10] The "best interest" standard is similarly used by many states and requires that the guardian make decisions by reference to the guardian's belief about what is the general best interest of the protected person.[11] Less restrictive approaches attempt to preserve the will, preferences, and rights of the individual, and these include the "maximum self-reliance standard" and the "least restrictive standard."[12] Finally, it should be noted some states are silent on the applicable decision-making standard for guardians.

There are other relevant factors that could affect the impact of a guardianship on a protected person's medical decision-making, health outcomes, and quality of life, as compared to a person with a less restrictive alternative. For example, states also vary in their qualifications and monitoring requirements for appointed guardians.

Finally, data about guardianships, conservatorships, and less restrictive alternatives are not uniformly collected. This is in part due to the lack of consistency in definitions regarding guardianships and less restrictive alternatives, including what would be considered a less restrictive alternative. There also does not appear to be a well-known mechanism to collect data, anonymized or not, on the outcomes on medical decision-making and quality of life as a result of these arrangements. The highly sensitive nature of the proceedings demands confidentiality, and such restrictions could make data collection and interpretation difficult. There are few if any organized databases that contain statewide data on guardianships, or on less restrictive alternatives to guardianships. This information is not often collected, and when it is collected, it is stored at the county level. These factors are all significant barriers to a well-designed study.

RELEVANT CURRENT AMA POLICY

Current AMA Policy H-140.845, "Encouraging the Use of Advance Directives and Health Care Powers of Attorney," supports the use of a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD). It further supports a national public health priority to "educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD."

DISCUSSION

The AMA is supportive of efforts to standardize laws concerning the establishment, modification, or termination of a guardianship. High-profile celebrity cases have highlighted existing challenges for individuals to overturn or modify guardianships. To the extent possible, guardianships should be limited in scope and duration, with clear pathways to modify or overturn a guardianship. In the meantime, less restrictive alternatives to guardianship should be favored and guardianships should be viewed as the last resort.

There are inconsistent standards for what constitutes a guardianship, when a guardianship should be established, what decision-making standard should be applied, and how guardians are vetted or appointed. These factors make it difficult to study the impact of less restrictive alternatives to guardianships and conservatorships on medical decision making,

health outcomes, and quality of life. Additionally, due to the unclear scope of guardianships in general (since some guardianships address financial interests only and some are a mix of both personal and financial interests), data collection and interpretation in this area may be impractical or otherwise overly burdensome. Though a study may not be feasible or recommended, the AMA encourages more extensive data collection efforts at the state level.

The AMA is supportive of actions that promote increased clarity on when guardianships should be instituted, what conditions should prompt modifications to the guardianship, and when a guardianship should be rescinded or terminated. Similarly, in the health care setting, promoting the use of less restrictive alternatives such as advance directives and health care powers of attorneys should continue to be promoted.

Due to an uneven legal landscape of different standards, terminology, and requirements, combined with inadequate data collection practices on the state level, and the inability to procure a reliable dataset from a reputable source, the Board believes it would not be feasible to complete a well-designed study to consider the impact on medical decision-making, health outcomes, and quality of life, when less restrictive alternatives to guardianships in the health care setting are used. It is likely that such a study would confirm what is already well-supported – that guardianships should be considered a last resort.

The Board encourages state and federal efforts to define and promote less restrictive alternatives to guardianships such as those detailed in the Uniform Guardianship Act. Our AMA is better positioned to support efforts to enact legislation like the Uniform Guardianship Act that preserves the will, preferences, and rights of the protected individual, especially as it relates to medical decisions that directly affect the individual's health outcomes and quality of life.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 402-A-24, and the remainder of the report be filed:

1. That our AMA encourages efforts to standardize laws concerning the establishment, modification, or termination of a guardianship, and favors less restrictive alternatives to guardianship, which should be viewed as a last resort.

2. That Policy H-140.845, "Encouraging the Use of Advance Directives and Health Care Powers of Attorney" be reaffirmed.

3. That our AMA supports efforts to reduce predatory behavior by participants in a guardianship system who may have potential financial conflicts of interest, including private organizations and entities, through education and regulation.

AMA Policy H-140.845, "Encouraging the Use of Advance Directives and Health Care Powers of Attorney,"

Our AMA will:
(1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies;
(2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility;
(3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD);
(4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD;
(5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems;
(6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas;

(7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license;
(8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives;
(9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives.

Fiscal Note: Less than $500

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21. ADVOCACY FOR MORE PROTECTIVE REGULATIONS ON DISTRIBUTION OF CANNABIS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **RECOMMENDATIONS ADOPTED AS FOLLOWS**
REMAINDER OF REPORT FILED
TITLE CHANGED
See Policies D-95.949, D-95.954 and H-95.923

INTRODUCTION

At the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 515-A-24, "Advocacy for More Stringent Regulations/Restrictions on Distribution of Cannabis," was adopted. This resolution resulted in Policy D-95.954, which directed the AMA "to study possible legislative, legal or regulatory means to make the cannabis industry responsible for increasing costs of medical and social care for people affected by the problems caused by cannabinoids similar to regulations for smoking cessation in the United States." Delegates' testimony, while limited, focused primarily on the need to cover the costs of treatment, effects of high-potency cannabis and cannabis-derived products, and medical impacts on individuals who use cannabis and cannabis-derived products. This report provides relevant background, discusses issues raised by the resolution, cites AMA policy, and makes recommendations.

BACKGROUND

As of the time of this report, cannabis was classified by the federal government as a Schedule I Controlled Substance. Without going into extensive detail, the Schedule I status has not prevented state-based legalization efforts. Almost every state has a robust legal and regulatory framework regulating cannabis. According to the National Conference of State Legislatures (NCSL), at least 47 states, the District of Columbia, and three territories (Guam, Puerto Rico, and the U.S. Virgin Islands) allow for the use of cannabis for medical purposes and/or low tetrahydrocannabinol (THC), and cannabidiol (CBD) products.[1] In general, each state defines the type(s) of qualifying medical condition(s) to authorize the personal use of cannabis for medical purposes. These laws have been adopted via legislative and/or ballot initiatives, and there are regulatory structures in each of these states, the District of Columbia, and the three territories, to implement the laws. All include requirements on cannabis growers, manufacturers, retailers, advertisers, home growers, and others. The NCSL also reports that at least 24 states and the District of Columbia allow for adult use of non-medical cannabis. The Board of Trustees (Board) notes that the AMA has worked closely with many medical societies on these laws.

Cannabis use is highly prevalent in the United States. In 2023, more than 43 million people over the age of 12 used cannabis in the past month, and 4.3 million people aged 12-20 used cannabis in the past month, according to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).[2] In 2022, nearly 62 million people used cannabis in the past year, according to SAMHSA.[3] "Teenage marijuana use is at its highest level in 30 years, and today's teens are more likely to use marijuana than tobacco," according to the American Academy of Child and Adolescent Psychiatry,[4] and the AMA Council on Science and Public Health (CSAPH) has detailed the clinical implications and public health effects of cannabis use in multiple previous reports.[5] The Board has provided the HOD with multiple reports concerning cannabis.[6] Finally, the AMA Cannabis Task Force also was instrumental in helping design and record a multi-episode podcast series on issues ranging from cannabis pharmacology to screening tools to counseling patients.[7]

Given the resolution's reference to tobacco, the Board notes that in 1998, more than 50 state and territory attorneys general entered into a Master Settlement Agreement (MSA)[8] with the nation's four largest tobacco companies: Philip Morris, R.J. Reynolds Tobacco Company, Brown & Williamson Tobacco Corporation, and Lorillard Tobacco Company. The state attorneys general claimed that the tobacco industry engaged in a wide range of culpable activity, including deceptive marketing and advertising about tobacco-related harms, youth impacts, and more. Additional states entered into similar agreements at the same time. Several dozen additional participating manufacturers also settled pursuant to the MSA. The MSA created a wide range of restrictions on tobacco-related marketing and advertising and other requirements. The MSA provided that states would receive approximately $206 billion over the first 25 years with additional funds to follow, but public health advocates have observed that much of the money does not go to tobacco cessation or prevention programs.[9] State attorneys general continue to sue the tobacco industry for ongoing deceptive acts.[10]

DISCUSSION

State Activity

States have taken a wide range of actions to restrict minors' exposure to legalized cannabis and cannabis-related marketing and advertising. States that have authorized cannabis for medical use or adult use restrict such use and sales to those 21 years of age and older. Also, marketing and advertising restrictions are common in states. This includes restrictions on content targeting children; print, radio and internet advertising; ads and promotions within a certain proximity to schools; content on public transportation; event sponsorship; and more.[11] The Board also points out that CSAPH Report 1 entitled, "Cannabis Therapeutic Claims in Marketing and Advertising," which was adopted at the 2024 Interim Meeting, provided significant background, research and analysis regarding cannabis-related advertising and marketing. The CSAPH recommendations in this report included asking the AMA to continue to monitor regulatory approaches concerning cannabis advertising and marketing. Without diving too deeply into the effects of these regulations, the Board wants to emphasize that not only is it continuing to monitor regulatory approaches as recommended by CSAPH, but also that the AMA has extensive policy (see below) – as well as model state legislation and other advocacy resources to help its national, state, and national medical specialty society partners enhance marketing and advertising restrictions relating to cannabis.

Social and Medical-Related Costs

The data varies for cannabis-related social and medical costs. One study of 248 individuals with cancer reported a median out-of-pocket cost of $80 per month for cannabis use.[12] Another study estimated that the cost for treating cannabis use disorder ranged between $3.5-$5.5 billion in the aggregate for hospital-related costs.[13] Cannabis use also has been linked to "increased risk of psychosis or schizophrenia in some users," as well as increased risks during pregnancy.[14] The American Lung Association has collected multiple reports showing additional adverse health effects, including increased risk of bronchitis, decreased immune system response, and more.[15] Other research shows that, "a marijuana comorbidity increases the cost of treating patients with alcohol problems and mood disorder diagnoses, implying that there may be real health consequences associated with marijuana abuse and dependence."[16]

Cannabis use has been linked to a wide range of other costs, including how "cannabis use has been shown to be associated with cognitive decline, impaired educational or occupational attainment, risk of other substance use disorders, and poor quality of life."[17] A 2024 study from the U.S. Federal Reserve Bank in Kansas City found that substance use disorders and homelessness increased in states that authorized cannabis for adult use; increased economic benefits for the states; and increased in offenses for intoxicated driving and disorderly conduct.[18] Other economic benefits include the tax revenue on U.S. sales of cannabis, which have been approximately $1.5 billion per month for several years—with projections for 2025 ranging between $30-$45 billion.[19] The cannabis beverage industry also is growing, as well. In fact, from an estimated $1.2 billion in 2023, the market is projected to grow to nearly $4 billion by 2030.[20] Depending on the type of individual cannabis or cannabis-derived product, the out-of-pocket cost to consumers can vary from $10 up to $100 (or more) for products such as pre-rolls, vapes, flowers, edibles, beverages, tinctures, oils, or topical creams. Depending on the amount purchased, a single product could cost several hundred dollars.

Use of Cannabis Tax Revenue

States vary significantly regarding how they distribute cannabis tax revenue. The most common allocation categories are state general funds, public health efforts (i.e., substance abuse prevention, mental health, etc.), recidivism, education, police enforcement, and transportation. While some states allocate 50 percent or more of cannabis tax revenue to public health efforts, some states allocate less than 10 percent. Most states allocate at least a portion of cannabis tax revenue to public health efforts. AMA Policy H-95.923 entitled, "Taxes on Cannabis Products," specifically "encourages states and territories to allocate a substantial portion of their cannabis tax revenue for public health purposes, including substance abuse prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts." The Board believes that states need to be more purposeful with respect to these allocations. As a result, the Board strongly supports public health uses for cannabis-related revenue and therefore, recommends that states enact policies to ensure that at least 50 percent of cannabis tax revenues are directed to these purposes.

Who Comprises the Cannabis Industry?

Before being able to hold an industry "responsible," per the directive contained in Resolution 515, it is important to identify who that industry represents. For example, the "cannabis industry" includes companies that manufacture cannabis products.[21] The "industry" also includes cannabis growers[22] and cannabis dispensary chains.[23] Moreover, there are numerous businesses that also fall under the definition of "cannabis industry" that provide legal, marketing, financial, and other supports to the cannabis industry—just like any other product in the United States. Unlike the large tobacco manufacturers, whose products, marketing, and other business practices were largely consistent across the nation, each cannabis company, manufacturer, and retailer is subject to the specific state (and in some cases, local) laws and regulations.

Legal Status and Enforcement of Cannabis Laws

The unique legal status of cannabis also deserves attention. First, the Board is aware of policy considerations at work regarding the rescheduling of cannabis. As noted above, cannabis is a Schedule I Controlled Substance, and there is no interstate commerce in cannabis. Yet, most states have authorized its use, and the federal government will generally not interfere in a state's regulatory authority governing retail or adult use if a state has authorized either or both. It is beyond the scope of this report to speculate about the implications of potential rescheduling or even the potential impacts of reclassifying hemp-derived cannabis products as cannabis. This is not to say that the federal government has not enforced the law.[24]

There also are multiple efforts already underway to hold the various players and entities that make up the "cannabis industry" responsible for cannabis-related harms. This includes state attorneys general that have been active in enforcing state laws regulating cannabis. For example:

- Colorado's attorney general filed suit against a cannabis company for alleged illegal marketing that exposed people under the age of 21 to high-potency cannabis products.[25]
- New York's attorney general successfully sued a cannabis dispensary operating without a license. [26]
- Connecticut's attorney general sued multiple companies for alleged violations of the state Unfair Trade Practices Act, including failure to comply with testing standards and misleading packaging designed to appeal to children.[27]
- The Missouri attorney general launched inquiries into multiple businesses that sell Delta-8 and Delta-9 goods on grounds that they potentially engaged in "deception, fraud, false promise, misrepresentation, unfair practices, and/or the concealment, suppression, or omission of material facts in connection with the sale or advertisement of CBD, Delta-8, and Delta-9 THC products."[28]
- The Nebraska attorney general filed suit against a business alleging violations for "failing to implement an age verification process, selling THC products to children, and selling products designed to appeal to children; Selling THC products which grossly understate or overstate the concentration of THC contained within the product and by failing to disclose which cannabinoids are contained in the product; Employing a purchase rewards program designed to increase sale frequency of addictive and psychoactive products, including to minors; and Selling THC products which are harmful when consumed."[29]
- The California attorney general filed suit against multiple companies, alleging the sale of "illegal inhalable hemp products in violation of Assembly Bill 45, failing to include warnings required by Proposition 65 for all commercial industrial hemp products, and engaging in unfair business practices."[30]

The Board emphasizes that these examples are just a snapshot into the legal actions taken by state attorneys general to enforce existing laws. In each case, the state lawsuit is based on specific state laws and regulatory requirements in effect. The Board believes that this is appropriate and commends the state attorneys general for these efforts.

There also are robust legal actions taken by the plaintiff's bar. This includes suits based on the federal Racketeer Influenced and Corrupt Organizations Act;[31] suits for deceptive marketing;[32] and product liability suits at the state and federal levels.[33] Furthermore, there are innumerable personal injury lawyers available to consider personal injury claims arising from cannabis use. The Board believes it is important to point out that there is no shortage of legal action already being taken to hold the cannabis industry responsible for alleged and real harms, as well as violations of state and federal laws.

AMA POLICY

The AMA has extensive policy regarding multiple aspects and issues concerning cannabis. This includes the AMA encouraging "states and territories to allocate a substantial portion of their cannabis tax revenue for public health purposes, including substance abuse prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts." (Policy H-95.923, "Taxes on Cannabis Products")

Related to the tobacco MSA, the AMA similarly "supports efforts to ensure that a substantial portion of any local, state or national tobacco litigation settlement proceeds be directed towards preventing children from using tobacco in any form, helping current tobacco users quit, and protecting nonsmokers from environmental tobacco smoke, and that any tobacco settlement funds not supplant but augment health program funding." (Policy H-495.983, "Tobacco Litigation Settlements")

The AMA also has complementary policy related to holding the pharmaceutical industry liable for actions related to "unethical and deceptive misbranding, marketing, and advocacy of opioids," which specifically calls on the AMA to support funds derived from opioid-litigation "be used exclusively for research, education, prevention, and treatment of overdose, opioid use disorder, and pain, as well as expanding physician training opportunities to provide clinical experience in the treatment of opioid use disorders." (Policy H-95-918, "Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs") Importantly, the Board believes that these policies emphasize the need for the AMA to encourage policymakers that funds related to cannabis tax revenue—or proceeds from state attorneys general lawsuits for cannabis-related violations of law—these monies be directed to public health needs.

AMA policy also addresses multiple, additional legislative and regulatory issues. This includes advocating for "for regulations requiring point-of-sale warnings and product labeling for cannabis and cannabis-based products regarding the potential dangers of use during pregnancy and breastfeeding wherever these products are sold or distributed." (Policy H-95.936, "Cannabis Warnings for Pregnant and Breastfeeding Women")

The AMA broadly encourages states "to enforce cannabis-related marketing laws and to publicize and make publicly available the results of such enforcement activities." (Policy D-95.958, "Marketing Guardrails for the "Over-Medicalization" of Cannabis Use") The AMA also has created model state legislation and advocacy materials "to help states implement the provisions of AMA policies H-95.924, "Cannabis Legalization for Adult Use" and H-95.936, "Cannabis Warnings for Pregnant and Breastfeeding People" that currently do not have such model language, including regulation of retail sales, marketing and promotion (especially those aimed at children), misleading health claims, and product labeling regarding dangers of use during pregnancy and breastfeeding." (Policy D-95.956, "Cannabis Product Safety")

The Board further highlights AMA's considerable policy concerning restrictions on tobacco, including but not limited to Policy H-495.973, "FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products." Although there was limited testimony to provide specific direction, based on all of the above, the Board recommends using AMA's tobacco policy as a guide to further the AMA's cannabis-related policy and adopting new and reaffirming existing policy to respond to the directive in Resolution 515-A-24. Finally, the Board recommends that Policy D-95.954, "Advocacy for More Stringent Regulations/Restrictions on the Distribution of Cannabis," be rescinded having been accomplished with this report.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) will advocate that any monies paid to the states, received as a result of a settlement or judgment, or other financial arrangement or agreement as a result of litigation for cannabis-related harms or violations of law, be used exclusively for research, education, prevention, and treatment of cannabis-related harms, as well as expanding physician training opportunities to provide clinical experience in the screening, diagnosis, and treatment of cannabis misuse and cannabis use disorder. (New HOD Policy)

2. That our AMA supports legislation and/or regulation of all cannabis products that:
   a. prohibits cannabis use in all places that tobacco use is prohibited, including in hospitals and other places in which health care is delivered;
   b. applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople as well as avenues for legal and financial penalties for marketing to youth;
   c. prohibits product claims of reduced risk or effectiveness as tobacco cessation tools;
   d. requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on all cannabis products;
   e. establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use;
   f. requires transparency and disclosure concerning product design, contents, and emissions; and
   g. prohibits the use of characterizing flavors that may enhance the appeal of such products to youth. (New HOD Policy)

3. That our AMA encourage state medical associations to strengthen existing cannabis marketing and advertising restrictions, including consideration of prohibitions on marketing and advertising to children. (New HOD Policy)

4. That our AMA support the review of conditions that states have approved to authorize cannabis for medical use and recommend the removal of those conditions without scientifically valid and well-controlled clinical trials supporting the use of cannabis. (New HOD Policy)

5. That Policy H-95.923, entitled "Taxes on Cannabis Products" be reaffirmed. (Reaffirm HOD Policy)

6. That Policy D-95.954, entitled "Advocacy for More Stringent Regulations/Restrictions on the Distribution of Cannabis," be rescinded. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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22. RANKED CHOICE VOTING

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

INTRODUCTION

Policy G-610.009 adopted at A-23, directs our AMA to study ranked choice voting. This report fulfills that directive.

Our American Medical Association study ranked-choice voting for all elections within the House of Delegates.

BACKGROUND

Ranked choice voting (RCV) is a system of voting in which voters rank all candidates in order of preference rather than voting for an individual candidate. The winner is then identified with one ballot based on the number of votes received. There are two methods that could be used to calculate results with RCV. For the purposes of this discussion, we will describe them as the rank one system and the points system.

Rank one system with one open position

The rank one system assigns one vote to each first rank choice. The winning vote getter is the candidate who receives 50% + 1 of total votes cast. If the position is not filled based on the first-ranked ballots, the lowest vote getter is dropped, and there is a redistribution of the lowest ranked candidate's votes to the second-place ranked candidate on those ballots. If a winner is still not identified, another candidate is dropped with redistribution of those votes and so forth as necessary. This process is repeated until a candidate is elected.

Rank one system with multiple open positions

When there are multiple candidates for multiple positions, as occurs in HOD elections, a threshold (quota) is set to determine how many votes a candidate needs in order to win a seat. The most common formula is the Droop quota:

$$\text{Quota} = (\text{Total Votes}/\text{Positions}+1)+1$$

If a candidate reaches the quota by counting the first-ranked votes, they win a position. If a candidate has more votes than needed, their extra votes are redistributed to voters' next choices, using one of the following proportional transfer methods:

- Fractional Transfer Method in which all votes for the elected candidate are transferred to the next preferred candidates at a reduced value, known as the transfer value. This value is calculated by dividing the surplus by the total number of votes the candidate received, ensuring that the total value of transferred votes equals the surplus.

- Random Selection Method in which a random sample of the elected candidate's ballots, equal to the number of surplus votes, is selected and transferred at full value to the next preferred candidates on those ballots.

If no candidate reaches the quota, the lowest-ranked candidate is eliminated, and their votes are transferred to the next choice on each ballot. This process continues until all positions are filled.

Points system

For the second method used in determining winners in RCV, a point value is attributed to each rank with the winning candidate/s having the highest point total. This system uses a majority of points earned not a tally of votes. Therefore, verifying a candidate has received a majority +1 of votes cast is not possible as each voter casts a "vote" for each candidate by assigning each a rank. Further complicating this methodology, the value assigned to each rank could be a source of considerable debate and lead to potential gaming of the system as voters consider how to rank the candidates.

Current RCV use

RCV has been used by a handful of American municipalities and in some international countries for decades. In recent years, some U.S. states and cities have considered or implemented RCV with varying degrees of acceptance and success. Internationally, Australia uses RCV for federal and state elections while Ireland uses it for presidential elections and parliamentary elections. The United Kingdom and New Zealand uses RCV for some local elections, with New Zealand exploring it further for other races. In the United States, Maine uses RCV for all statewide elections, while Alaska adopted RCV for both state and federal elections starting in 2022. Cities who have implemented RCV include Sante Fe, NM; Portland, ME; New York, NY; Minneapolis, MN and San Francisco, CA. Some state Democratic and Republican parties use RCV for their primaries or conventions. Several places have considered and ultimately decided not to implement it or have repealed it after initially adopting it including Massachusetts; Burlington, VT; Aspen, CO; North Dakota; and Tennessee.

Per their Internal Operating Procedures, the AMA Medical Student Section has utilized RCV as of their A-23 elections. In their brief experience, it worked well for contests with three or less candidates. However, with more than three candidates, the complexity of applying this methodology took considerable time to determine the winner. Note that the AMA MSS does not have multi-seat positions to fill as each position is singular.

DISCUSSION

Elections in our AMA HOD have multiple complexities that would preclude the application of ranked choice voting. Per our bylaws, candidates must receive a majoritiy+1 of votes cast to be elected. This would preclude the application of the RCV points system, previously described. In addition, AMA policy G-610.090 states that "the final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House." Given that RCV necessarily requires each voter to rank each candidate on their ballot, compliance with this policy would not be possible, even when utilizing the rank one system.

Our current electronic voting system provider, LUMI, indicated that their system could accommodate RCV, but the specific methodology would need to be defined, point vs rank one system. Additionally, for rank one multi-seat contests, the quotient (such as the Droop quota formula) and the redistribution method to be utilized would also need to be predetermined.

When queried about the possibility of using RCV, our LUMI providers specifically pointed out that applying either RCV methodology would significantly increase the time necessary to determine and verify each election outcome when compared to our current method, giving an immediate result followed by run-off votes as needed, as utilized in our Election Session.

CONCLUSION

The voting system used in our HOD should be fair, simple to administer and with easily verified results that can later be made public per our rules. Our current electronic system accomplishes these goals and has performed expediently at our recent Election Sessions. For elections such as ours, which include multiple candidates for multiple seats, RCV is considerably more complicated to administer. Additionally, using RCV would make it impossible to make public the results of our secret ballots as required in our policy. Therefore, your Board believes the additional complexities that RCV brings to the voting and tabulation processes would not benefit our HOD and recommends that we retain our current system.

RECOMMENDATION

The Board recommends that Policy G-610.009 be rescinded having been accomplished by this report and that the remainder of the report be filed.

Fiscal Note: Minimal

RELEVANT AMA POLICY

HOD Policy G-610.090 - AMA Election Rules and Guiding Principles

VIII. Election process

1. At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place their name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker.
2. Nominating speeches for unopposed candidates for office, except for President-elect, will not be heard.
3. AMA elections will be held on Tuesday at each Annual Meeting.
4. Voting for all elected positions including runoffs will be conducted electronically during an Election Session to be arranged by the Speaker.
5. All delegates eligible to vote must be seated within the House at the time appointed to cast their electronic votes.
6. The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.
7. The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments.

23. FINANCIAL ASSISTANCE TO FACILITATE ATTENDANCE AT MSS MEETINGS

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy G-665.998

American Medical Association (AMA) Policy G-665.998, Mitigating the Cost of Medical Student Participation in AMA Meetings, directs the AMA in part to "explore alternate mechanisms to provide financial assistance to facilitate attendance at MSS meetings with a report back at the 2025 Annual Meeting."* As noted in BOT Report 35-A-24, from which AMA Policy G-665.998 originated, there are tax implications for AMA and for medical students of any travel assistance provided directly by AMA. For this reason, and as directed by AMA Policy G-665.998, this report provides an update solely on ongoing efforts to identify "alternate" funding mechanisms, which are sources of travel assistance apart from direct AMA funding. AMA Policy G-665.998 separately directs the AMA to "promote the value of membership and meeting attendance to encourage financial support by medical schools and other funding sources" and to "explore mechanisms to mitigate the cost of meeting attendance for medical students." While this work is also ongoing, it also is not the subject of this report.

BACKGROUND

BOT Report 35-A-24 examined the estimated costs and funding opportunities for medical student travel to AMA meetings. The report concluded that funding is available from a variety of sources, and that where funding is available, out-of-pocket student spending is modest. However, for students who cannot access funding, travel costs present a substantial barrier to meeting attendance.

BOT Report 35-A-24 also detailed existing sources of funding for student travel to AMA meetings, which include:

- The AMA Section Involvement Grant (SIG) program provides each local MSS section (i.e., medical school chapter) with up to two travel grants of up to $250 each per academic year. To receive a travel grant, the local

* See Appendix for full text of AMA Policy G-665.998.

section must have already submitted a SIG application for a recruitment, engagement, or community service event in the same program year. 61 SIG travel grants were awarded in 2024 (38 for Annual/Interim meetings and 23 for the Medical Student Advocacy Conference). Additionally, local MSS sections may use their AMA membership commission dollars (i.e., a portion of AMA membership revenue shared with them in exchange for recruiting new members) to fund member travel to MSS meetings. Both of these funding opportunities remain in place for 2025.

- AMA funds travel to Annual/Interim meetings for a select group of medical students who attend schools with historically low attendance at MSS meetings and who identify with groups that are underrepresented or disadvantaged in medicine. In 2025, AMA will continue to award 28 of these travel grants of up to $500 each.

- Common non-AMA travel funding sources include medical schools, local MSS sections, and state/specialty medical societies.

UPDATE

Since the 2024 Annual Meeting, the AMA has collaborated with the AMA Foundation to develop a new leadership development program for medical trainees. Beginning in 2025, the Foundation's Leadership Development Institute (LDI) will include a new Health Policy and Patient Advocacy (HPPA) cohort. This new cohort will provide a year-long opportunity for medical students and residents/fellows to gain insight into health policy processes in organized medicine and state/federal government, as well as to develop leadership skills and competencies to become health policy and patient advocates. Benefits of participation include virtual education sessions and mentorship opportunities with seasoned physician members of the AMA, as well as funding support to attend select AMA meetings. These meetings include the AMA Medical Student Advocacy Conference (for medical student cohort members) or the AMA National Advocacy Conference (for resident/fellow cohort members) in the Spring, and culmination activities in conjunction with the AMA Annual Meeting in June. A total of 10 positions will be available in the inaugural HPPA cohort. Additional information about this opportunity is available at https://amafoundation.org/programs/leadership/. To be clear, this AMA Foundation initiative is not a travel funding opportunity. It serves as a unique example of an alternative way to engage more medical students in AMA advocacy.

Other alternate travel funding mechanisms remain to be explored, and the Board looks forward to providing an additional update in the future.

RECOMMENDATIONS

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

1. That AMA policy G-665.998(3), Mitigating the Cost of Medical Student Participation in AMA Meetings, be amended by addition and deletion:
   (3) Our AMA will develop a mechanism ~~explore alternate mechanisms~~ to provide financial assistance to facilitate medical student leadership attendance at ~~MSS~~ the Annual and Interim Medical Student Section meetings, to be implemented no later than ~~with a report back at~~ the ~~2025~~ 2026 Annual Meeting, subject to confirmation by the AMA's outside tax counsel that such mechanism will not result in adverse tax or other legal consequences to the AMA. (Modify HOD Policy)

Fiscal Note: Modest – between $1,000 and $5,000

Appendix: Relevant AMA Policy

G-665.998 Mitigating the Cost of Medical Student Participation in AMA Meetings
1. Our American Medical Association will promote the value of membership and meeting attendance to encourage financial support by medical schools and other funding sources.
2. Our AMA will explore mechanisms to mitigate the cost of meeting attendance for medical students.
3. Our AMA will explore alternate mechanisms to provide financial assistance to facilitate attendance at MSS meetings with a report back at the 2025 Annual Meeting.

24. CREATION OF AN AMA COUNCIL WITH A FOCUS ON DIGITAL HEALTH TECHNOLOGIES AND AI

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy G-615.998

INTRODUCTION

At the 2024 Annual Meeting of the House of Delegates (HOD), Policy G-615.998, "Creation of an AMA Council with a Focus on Digital Health Technologies and AI," was adopted and directed the AMA to establish a task force by I-24 focused on digital health, technology, informatics, and augmented/artificial intelligence (AI) with the potential to transition of this task force to a new council and report back at A-25 on this transition.

BACKGROUND:

Management (MGMT) report 9-I-24

While the AMA has internal staff focused on supporting physicians with optimizing existing technology and preparing for the future of health care technology, the AMA currently does not have an advisory body that is dedicated to guiding the success of technology adoption. With the volume of resolutions around the topic of technology over the last few years, the HOD called for the creation of a task force focused on digital health technologies, AI, and clinical informatics.

A task force charter (MGMT Report 9-I-24) was proposed and approved by the AMA Board of Trustees in September 2024. The AMA Task Force on AI, Digital Health, and Informatics was set to be established by the 2024 Interim Meeting and remain active through 2026 to assess long-term HOD input on AI, digital health, and informatics, identify gaps in resources and AMA policy, and ensure physicians' voices shape health care technology advancements. It was determined that after two years, a decision would be made on the long-term model for HOD input.

As outlined in the charter, the 22-member task force would include representation from the AMA board of trustees (BOT), council, and HOD, in addition to two to four members of the public. The task force would have two co-chairs. Councils would nominate representatives, with additional suggestions from the Senior Management Group. HOD members were permitted to self-nominate, and final approval rested with the AMA Board Chair.

Members would commit to four in-person meetings over two years in addition to two to three virtual meetings per year. Regular updates were scheduled to be presented at AMA Annual and Interim Meetings, with reports provided to the AMA BOT as requested.

DISCUSSION

Task force members

The AMA Task Force on AI, Digital Health, and Informatics was launched at the 2024 Interim meeting. The following 22 individuals were selected to serve on the task force:

Michael Suk, MD, JD, MPH, MBA and David Aizuss, MD from the BOT serve as Task Force Co-Chairs. They are joined by fellow BOT and task force member Lynn Jeffers, MD. Representation from AMA councils include: Rebecca Brendel, MD, JD from the AMA Council on Ethics and Judicial Affairs who has observer status; Seema Sidhu, MD from the Council on Medical Education; Steven L. Chen, MD, MBA from the AMA Council on Medical Service; Tripti Kataria, MD, MPH, MBA, FASA from the Council on Legislation; Padmini Ranasinghe, MD, MPH, FACP, FACPM from the Council on Science and Public Health; Gary R. Katz, MD, MBA, FACEP who represents the Council on Long Range Planning & Development; and Jerry Abraham, MD, MPH, CMQ, Chair of the Council on Constitution and Bylaws.

Delegate task force members include: Ohio delegate, Robyn Chatman, MD, MPH, FAAFP, CPHIMS, CHEP; Young Physicians Section alternate delegate, Christopher Libby, MD, MPH, FACEP; Medical Student Section alternate delegate, Druv Bhagavan; American College of Radiology alternate delegate, Adam Prater, MD, MPH; College of American Pathologists delegate, Mark Synovec, MD; and Department of Veterans Affairs delegate, Carolyn Maureen Clancy, MD, MACP.

Representatives from AMA Group Members include Sanford Health's Roxana Lupu, MD, MBA and Kaiser Permanente's Vincent Liu, MD, MSc.

Lastly, the task force includes members of the public: Tom Lawry from Second Century Tech, LLC, Eric Langshur of Abundant Ventures, Lisa Dykstra of CHIME, and John Whyte, MD, MPH of WebMD.

Status update

The task force held its inaugural formal meeting on February 16, 2025. This meeting provided an opportunity to introduce members, establish initial goals and objectives, and discuss the key needs required to develop informed recommendations.

During the session, members received an overview of the AMA's organizational structure and existing AMA work related to digital health, AI, and informatics, including available resources, content, advocacy efforts, and collaborations. Additionally, an expert guest speaker delivered a presentation on AI deployment within Advocate Health, outlining key areas of focus, risk mitigation strategies, current use cases, and potential opportunities for the AMA to enhance its leadership in the AI landscape.

The task force has divided its objectives into two primary focus areas:

1. Positioning the AMA as the Critical Voice for Physicians in AI and Digital Health: Identifying key opportunities for the AMA to assert itself as the definitive and unique representative of physicians in the evolving landscape of AI, digital health, and informatics.
2. Developing Cross-Organizational Governance Concepts: Creating appropriate governance frameworks that span the AMA's organizational structure to ensure a cohesive and strategic approach to AI and digital health initiatives.

To further refine these focus areas, task force members engaged in discussions centered on the following key questions:

1. What does success look like for this task force?
2. What should be the key priorities and action items?
3. What is needed to make a well-informed recommendation at the end of the two-year charter period?

The task force is currently synthesizing insights from the initial meeting and working to define specific areas of focus and additional informational needs that will guide its final recommendations. The next meeting is scheduled for June 12, 2025, with additional virtual meetings to be scheduled as needed.

In the interim, AMA staff will continue to provide updates on existing AMA initiatives related to AI, digital health, and clinical informatics, ensuring the task force has a comprehensive understanding of ongoing internal efforts.

AMA research and resources on AI, digital health, and clinical informatics

The AMA is committed to researching health care technology, including AI and digital health landscape, and developing resources and programming to support physicians in getting involved in the design, development, and deployment of these tools across the industry.

In February 2024, the AMA released a foundational AI landscape report as part of its Future of Health work titled, "The Emerging Landscape of Augmented Intelligence in Health Care". The report aims to create a common lexicon for AI in health care, explore the risks, identify current and future use cases, and provide guidance for physicians looking to leverage these tools in practice today.

In November 2024, the AMA repeated its AI Physician Sentiments survey to continue to understand physician sentiments around AI, including opportunities, current use cases and needs around education and support for the implementation and use of AI. Compared to 2023, we saw a significant increase in physician excitement over AI and current use of AI.

The AMA ChangeMedEd initiative works with partners across the medical education continuum to help produce a physician workforce that meets the needs of patients today and in the future. As part of these efforts, an Artificial Intelligence in Health Care learning series was recently published on the AMA EdHub. These modules are geared towards medical students and physician learners, and introduce key concepts related to artificial intelligence and machine learning in health care.

The AMA has also crafted a framework to promote the development and use of responsible, evidence-based, unbiased and equitable health care AI. This ethics-evidence-equity framework envisions the use of AI to advance the quadruple aim – enhancing patient care, improving population health and clinician work life and reducing costs – and defines the responsibilities of developers, health care organizations (deployers), and physicians to put the framework into action.
In 2024, the AMA created an AI Specialty Collaborative with over 22 specialty associations signing up to participate. The goal of the collaborative is to ensure the physician voice is leading in a united way as AI in health care continues to expand. This group will continue to come together in 2025 following strong interest in keeping this collaborative going for another year. Additionally, The AMA Physician Innovation Network (PIN) is a network of physicians that aims to connect them with research-driven content and programs to make clinical technology work for them.

The AMA's Digital Health Implementation Playbooks help physicians better integrate technology solutions into clinical practice and extend care beyond the exam room. Developed in collaboration with more than 30 partners, the Playbooks offers medical care teams and administrators a guide to the most efficient path for applying digital health solutions, including key steps, best practices, and resources to accelerate and achieve technology adoption. Current playbooks and reports cover telehealth, remote patient monitoring, and health at home, with others in development focused on clinical informatics, AI governance, and creating an integrated technology roadmap.

AMA's Future of Digital Health Blueprint is an initiative developed to establish standards for optimized digital health, including re-centering care around the patient-physician relationship, adopting payment models that support high-value care, designing with an equity lens, and creating technologies that reduce fragmentation. This body of work includes real-world case studies, a Return on Health framework, and various issue briefs, all designed to advance digitally enabled care.

The AMA STEPS Forward Innovation Academy has tools, resources, and programming designed to guide physicians, practices, and health systems in optimizing and sustaining telehealth and other clinical technologies at their organizations. This includes an upcoming AI Governance Learning Collaborative kicking off in April 2025.

The AMA developed the CPT® Developer Program to assist developers in translating ideas into innovations. The program is dedicated to developers' needs and providing them with access to high quality AMA CPT content and resources.

AMA POLICY

The AMA has a significant amount of existing policies relevant to topics impacting health care technology, AI, and digital health (including telehealth).

Electronic Health Records (EHR) Policies

Redefining "Meaningful Use" of Electronic Health Records

The AMA will work with the federal government and the Department of Health and Human Services to: (1) set realistic targets for meaningful use of EHRs such as percentage of computerized order entry, electronic prescribing, and percentage of inclusion of laboratory values; and (2) improve the EHR incentive program requirements to maximize physician participation.

In addition, AMA will continue to advocate that, within existing AMA policies, the Centers for Medicare and Medicaid Services (CMS) suspend penalties to physicians and health care facilities for failure to meet Meaningful Use criteria (Policy D-478.982, "Redefine "Meaningful Use" of Electronic Health Records").

EHR Interoperability

Our AMA will enhance efforts to accelerate development and adoption of universal, enforceable EHR interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System.

AMA supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange.

Our AMA will: (1) develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges; (2) continue efforts to promote interoperability of EHRs and clinical registries; (3) seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates; and (4) seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private.

Additionally, AMA will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care.

AMA will also seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology (ONC) to establish regulations that require universal and standard interoperability protocols for EHR vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data.

Further, AMA will review and advocate for the implementation of appropriate recommendations from the "Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care," a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the ONC, and the CMS (Policy D-478.972, "EHR Interoperability").

Physician Time Spent with Patients and on Hospital Documentation

AMA policy on the time physicians spend with their patients and on hospital documentation is as follows:

1. AMA advocates for continued research into quality determinants--including time spent with patients--and lead the effort to develop and appropriately implement quality indicators, i.e., clinical performance measures;
2. AMA will continue to work with (1) accrediting bodies and government agencies to substantially reduce hospital paperwork; and (2) EHR system developers to ensure that the perspectives of practicing physicians are adequately incorporated, to ensure the standardization and integration of clinical performance measures developed by physicians for physicians, and to ensure a seamless integration of the EHR into the day-to-day practice of medicine (Policy D-450.980, "Physician Time Spent with Patients and with Hospital Documentation")

Health Information Technology (HIT) Principles

Our AMA will: promote the development of effective EHRs in accordance with the following HIT principles. Effective HIT should:

1. Enhance physicians' ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.

Our AMA will also utilize HIT principles to:

1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of "Information Blocking."

It is AMA policy that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules (Policy H-478.981, "Health Information Technology Principles").

Technology and the Practice of Medicine

Further, AMA encourages the collaboration of existing AMA Councils and working groups on matters of new and developing technology, particularly EHRs and telemedicine (Policy G-615.035, "Technology and the Practice of Medicine").

AI Policies

The Potentially Dangerous Intersection Between AI and Misinformation

Regarding the potentially dangerous intersection between AI and misinformation, AMA (1) will study and develop of recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other AI-generated medical advice or content, and that our AMA propose appropriate state and federal regulations; (2) work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice; (3) encourage physicians to educate our patients about the benefits and risks of consumers facing LLMs including GPTs; and (4) support publishing groups and scientific journals to establish guidelines to regulate the use of AI in scientific publications that include detailing the use of AI in the methods, exclusion of AI systems as authors, and the responsibility of authors to validate the veracity of any text generated by AI (Policy H-480.935, "Assessing the Potentially Dangerous Intersection Between AI and Misinformation").

AI in Medical Education

Further, AMA encourages: (1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards; (2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI; (3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes; (4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules; (5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems; (6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies; (7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients; (8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies; (9) institutional leaders and academic deans to proactively accelerate the inclusion of non-clinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and (10) close collaboration with and oversight by practicing physicians in the development of AI applications (Policy H-295.857, "Augmented Intelligence in Medical Education").

Use of AI for Prior Authorization

Regarding the use of AI for prior authorization, AMA advocates for greater regulatory oversight of the use of AI for review of patient claims and prior authorization requests, including whether insurers are using a thorough and fair process that:

1. Is based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature;
2. Includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review; and
3. Requires such reviews include human examination of patient records prior to a care denial (Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization).

AI in Health Care

As a leader in American medicine, AMA has a unique opportunity to ensure that the evolution of AI in medicine benefits patients, physicians, and the health care community. To that end, AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that: (1) is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team; (2) is transparent; conforms to leading standards for reproducibility; (3) identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and (4) safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI (Policy H-480.940, "Augmented Intelligence in Health Care").

The AMA also supports the use and payment of AI systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end, AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on clinical validation, alignment with clinical decision-making that is familiar to physicians, and high-quality clinical evidence.
4. Payment and coverage for health care AI systems must be informed by real world workflow and human-centered design principles; enable physicians to prepare for and transition to new care delivery models; support effective communication and engagement between patients, physicians, and the health care team; seamlessly integrate clinical, administrative, and population health management functions into workflow; and seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, AMA opposes:
    a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage

   b. The imposition of costs associated with acquisition, implementation, and maintenance of health care AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. The AMA will further advocate:
   a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
   b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
   c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Alongside national medical specialty societies and state medical associations, AMA will: (1) identify areas of medical practice where AI systems would advance the quadruple aim; (2) leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts; (3) outline new professional roles and capacities required to aid and guide health care AI systems; and (4) develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders.
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it (Policy H-480.939, "Augmented Intelligence in Health Care").

Data Privacy & Payment Policies

Supporting Improvements to Patient Data Privacy

The AMA will strengthen patient and physician data privacy protections by advocating for legislation that reflects the AMA's Privacy Principles with particular focus on mobile health apps and other digital health tools, in addition to non-health apps and software capable of generating patient data. Further, the AMA will work with appropriate stakeholders to oppose using any personally identifiable data to identify patients, potential patients who have yet to seek care, physicians, and any other health care providers who are providing or receiving health care that may be criminalized in a given jurisdiction (Policy D-315.968, "Supporting Improvements to Patient Data Privacy").

Clinical Information Technology Assistance

The AMA supports a full refundable federal tax credit or equivalent financial mechanism to indemnify physician practices for the cost of purchasing and implementing clinical information technology, including EHR systems, e-prescribing and other clinical information technology tools, in compliance with applicable safe harbors (Policy D-478.990, "Clinical Information Technology Assistance").

Payment for Electronic Communications

Moreover, the AMA will: (1) advocate that pilot projects of innovative payment models be structured to include incentive payments for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, and email and telephone communications; (2) continue to update its guidance on communication and information technology to help physicians meet the needs of their patients and practices; and (3) educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians (Policy H-385.919, "Payment for Electronic Communication").

Mobile Health Technology

Regarding the integration of mobile health technology into practice, AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that:

1. Support the establishment or continuation of a valid patient-physician relationship;
2. Have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness;
3. Follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes;
4. Support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication;
5. Support data portability and interoperability in order to promote care coordination through medical home and accountable care models;
6. Abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app;
7. Require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and
8. ensure that the delivery of any services via the app be consistent with state scope of practice laws.

AMA also supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information.

AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.

AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.

The AMA encourages physicians to (1) consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws; and (2) alert patients to the potential privacy and security risks of any mHealth apps that they prescribe or recommends, and document the patient's understanding of such risks.

Additionally, AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy, and encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery (Policy H-480.943, "Integration of Mobile Health Applications and Devices into Practice").

Telehealth Policies

Ethical Practice in Telemedicine

The AMA also has an array of policies regarding telehealth including ethics, equity, reimbursement, licensure, and coding.

Physicians who respond to individual health queries or provide personalized health advice electronically through a telehealth service in addition should:

1. Inform users about the limitations of the relationship and services provided.
2. Advise site users about how to arrange for needed care when follow-up care is indicated.
3. Encourage users who have primary care physicians to inform their primary physicians about the online health consultation, even if in-person care is not immediately needed.
4. Physicians who provide clinical services through telehealth/telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. In the context of telehealth/telemedicine they further should:

5. Be proficient in the use of the relevant technologies and comfortable interacting with patients and/or surrogates electronically.
6. Recognize the limitations of the relevant technologies and take appropriate steps to overcome those limitations. Physicians must ensure that they have the information they need to make well-grounded clinical recommendations when they cannot personally conduct a physical examination, such as by having another health care professional at the patient's site conduct the exam or obtaining vital information through remote technologies.
7. Be prudent in carrying out a diagnostic evaluation or prescribing medication by: (1) establishing the patient's identity; (2) confirming that telehealth/telemedicine services are appropriate for that patient's individual situation and medical needs; (3) evaluating the indication, appropriateness and safety of any prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction; and (4) documenting the clinical evaluation and prescription.
8. When the physician would otherwise be expected to obtain informed consent, tailor the informed consent process to provide information patients (or their surrogates) need about the distinctive features of telehealth/telemedicine, in addition to information about medical issues and treatment options. Patients and surrogates should have a basic understanding of how telemedicine technologies will be used in care, the limitations of those technologies, the credentials of health care professionals involved, and what will be expected of patients for using these technologies.
9. As in any patient-physician interaction, take steps to promote continuity of care, giving consideration to how information can be preserved and accessible for future episodes of care in keeping with patients' preferences (or the decisions of their surrogates) and how follow-up care can be provided when needed. Physicians should assure themselves how information will be conveyed to the patient's primary care physician when the patient has a primary care physician and to other physicians currently caring for the patient.
10. Collectively, through their professional organizations and health care institutions, physicians should:
    a. Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.
    b. Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.
    c. Routinely monitor the telehealth/telemedicine landscape to:
    d. Identify and address adverse consequences as technologies and activities evolve; and
    e. Identify and encourage dissemination of both positive and negative outcomes (Policy 1.2.12, "Ethical Practice in Telemedicine").

Evolving Impact of Telemedicine

Our AMA:

1. Will evaluate relevant federal legislation related to telemedicine;
2. Urges (1) CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship; and (2) professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
3. Encourages (1) professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice; and development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
4. Will work with (1) CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms; and the Federation of State Medical Boards (FSMB) and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries;
5. Will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine; and
6. Will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted (Policy H-480.974, "Evolving Impact of Telemedicine").

Licensure and Telehealth

Additionally, the AMA will work with the FSMB, state medical associations and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient in the state without penalty if the following conditions are met:

1. The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action.
2. There is a pre-existing and ongoing physician-patient relationship.
3. The physician has had an in-person visit(s) with the patient.
4. The telehealth services are incident to an existing care plan or one that is being modified.
5. The physician has verified that the telehealth services are covered under the physician's medical liability insurance policy that satisfies applicable state legal requirements.
6. Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules.

It is the policy of our AMA that a state with a patient compensation fund should consider the impact on the fund of telehealth use by out-of-state physicians providing continuity of care to existing patients in the fund's state. Physicians and patients should be made aware that a state's patient compensation fund may not be applicable when care using interstate telehealth is provided (Policy D-480.960, "Licensure and Telehealth").

Equity in Telehealth and Health Technology

The AMA also recognizes access to broadband internet as a social determinant of health.

The AMA encourages (1) initiatives to measure and strengthen digital literacy, with appropriate education programs, and with an emphasis on programs designed with and for historically marginalized and minoritized populations; and (2) telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations.

AMA supports efforts to design and to improve the usability of existing EHR and telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with other mental or physical disabilities.

AMA encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.

AMA supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations.
AMA also supports efforts to ensure payers allow all contracted physicians to provide care via telehealth.

AMA is opposed to efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians.
AMA will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

The AMA encourages the development of improved solutions to incorporate structured advance care planning (ACP) documentation standards that best meet the requisite needs for patients and physicians to easily store and access in the EHR complete and accurate ACP documentation that maintains the flexibility to capture unique, patient-centered details.

Further, AMA encourages hospitals, health systems, and physician practices to provide a method other than electronic communication for patients who are without technological proficiency or access (Policy H-480.937, "Addressing Equity in Telehealth and Health Technology").

Standardized Coding for Telehealth Services

Regarding coding, AMA policy supports legislation, regulation and/or advocacy to public and private payors, whichever is relevant, to ensure that payors utilize consistent reporting and coding rules to identify telehealth services in claims (Policy H-190.954, "Standardized Coding for Telehealth Services").

Reimbursement for Telehealth

Related to reimbursement, AMA will work with third-party payers, CMS, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians (Policy D-480.965, "Reimbursement for Telehealth").

CONCLUSION

Given the task force has a two-year term, this report serves as an update on progress to-date. The task force members continue to discuss areas of focus and identify key needs required to develop an informed recommendation by the 2026 Interim meeting.

RECOMMENDATIONS

The Board of Trustees recommends that our AMA Task Force on AI, Digital Health, and Informatics work toward an informed recommendation on the long-term model for HOD input with a report back at the 2026 Interim meeting and that the remainder of this report be filed.

Fiscal Note: $330,000

25. AMA PUBLIC HEALTH STRATEGY UPDATE

Informational report; no reference committee hearing.

HOD ACTION: FILED

BACKGROUND

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

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

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

In recent months there have been a number of concerning policies that threaten to weaken our public health infrastructure, undermine science and evidence-based practice, and weaken protections for underserved and marginalized communities, which will result in increasing health inequities. 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.

DISCUSSION

What is Public Health?

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

Connection with Health Equity

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

USPSTF

- The Journal of the American Medical Association (JAMA) continues to publish the recommendations of the USPSTF. These recommendations are also featured in the AMA *Morning Rounds* newsletter.
- The AMA submitted comments on the USPSTF recommendation related to food insecurity.
- The AMA has 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 with access to preventive services. The U.S. Supreme Court is scheduled to hear oral arguments in April of 2025, on whether the structure of the USPSTF violates the Constitution's appointments clause and in declining to sever the statutory provision that it found to unduly insulate the task force from the Health & Human Services (HHS) secretary's supervision.

ACIP

- The AMA's ACIP Liaison joined the AMA Update podcast throughout the year to provide updates to physicians.
    - The March 8, 2024, episode covered the latest ACIP COVID vaccine recommendations, which include an additional dose of the updated vaccine for those 65 and reviewed CDC's new isolation guidelines after testing positive for COVID.
    - The July 8, 2024, episode covered recommendations for RSV, COVID-19, and pneumococcal vaccines as well as updated information on flu vaccines.
    - The September 4, 2024, episode covered the new COVID vaccine coming out in Fall 2024.

  - The November 6, 2024, episode covered what physicians need to know about the new recommendations from CDC's ACIP for COVID vaccine frequency for seniors as well as updates on the RSV vaccine.
- The February 26-28, 2025, ACIP meeting was postponed. The AMA joined a letter to the Secretary of HHS, the Interim Director of the Centers for Disease Control and Prevention (CDC), and U.S. Senator Bill Cassidy calling for the rescheduling of this critical meeting and the reconciling of the absent portal for public remarks to ensure Americans receive the information needed to protect themselves against vaccine-preventable illnesses, confirming immunization's importance in the mission to make America healthier.

B. Help prevent cardiovascular disease (CVD) by addressing major risk factors (AMA Strategic Priority led by the Improving Health Outcomes team)

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 one in four deaths among adults.[5] Two major risk factors for CVD are hypertension and type 2 diabetes.

- 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 free program has demonstrated effectiveness in a variety of health care settings from large health care organizations (HCO) to community health centers. Participating HCOs are provided with clinical based practice facilitation and a personalized dashboard with performance metrics.[6] The AMA MAP ™ set of solutions is expanding to include management for other cardiovascular disease risk factors, including cholesterol, prediabetes, and post-partum hypertension.
- In 2024, the AMA was awarded a multi-year CDC grant to implement three projects aimed at improving the quality of cardiovascular disease-related preventive care in Community Health Centers/Federally Qualified Health Centers. The funding will allow AMA to scale its existing quality improvement program. The goal is to help 500,000 patients achieve blood pressure control.
- AMA MAP™ 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. In 2024, the AMA submitted one of its prediabetes quality measures to the Centers for Medicare & Medicaid Services (CMS) for consideration for inclusion in the Merit-based Incentive Payment System (MIPS) Program. In January 2025, the measure, Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes, was recommended for adoption and the approval vote was unanimous.
- Additionally, the AMA, in collaboration with the AHA, developed Target: BP™, which recognizes organizations that have achieved milestones in their commitments to improving blood pressure control. In 2024, Target: BP ™ Achievement Awards recognized 1,812 HCOs for efforts to prioritize control of their patients' blood pressure (BP) through attested 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 34 million patients, including 9 million with hypertension. Nearly half of participating organizations are nonprofit health centers that receive federal funding to reach medically underserved populations, known as federally qualified health centers, reflecting the associations' shared commitment to improving health equity.
- One in three adults enrolled in Medicaid have hypertension and since 2022, the AMA has worked to increase Medicaid coverage to ensure that beneficiaries receive home blood pressure devices and have their condition monitored by physician-led care teams. As of October 2024, 22 states have coverage for self-measured blood pressure clinical services and home BP devices.
- Another cardiovascular disease risk factor is obesity, which is linked to cardiovascular disease mortality, independent of other risk factors. The AMA is collaborating with Federation members, including the American College of Physicians and the Obesity Medicine Association, to explore opportunities for improving access to evidence-based obesity treatments.

C. Screening and Reducing Risk for Dementia

Under the Navigating Brain Health and Dementia Project, the AMA reviewed available materials on the AMA Ed Hub addressing Brain Health and Dementia to determine potential gaps, developed three CME webinars, seven short videos, and one podcast, and continued collaboration and relationship building with the Alzheimer's Association and other partners. The webinars were developed in collaboration with CDC and the Alzheimer's Association, and focused on (1) the Screening and Diagnosis of Alzheimer's Disease and Related Dementias (ADRD), (2) Reducing Risk of ADRD, and (3) Treatment of ADRD. The seven YouTube short videos addressed the growing impact of the disease, key considerations around screening, addressing risk factors, as well as addressing cardiovascular risk factors, blood pressure control, and loneliness. For the webinars, there have been a total of 4,541 views; for the short videos, there have been a total of 7,962 views on YouTube.

With recently awarded funding from the CDC, this important work will continue through the convening of a workgroup comprised of clinicians and/or researchers with expertise in ADRD research, clinical care, and/or education. The workgroup will inform the design of a needs assessment to better understand the current knowledge, daily practices, challenges, and training needs of physicians and other health care professionals in the prevention, screening, diagnosis, and treatment of ADRD. The workgroup and needs assessment findings will inform the development of education opportunities, training, communication strategies, and resources for health care professionals involved in the assessment and management of ADRD.

D. 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 contains two different sets of strategies – one targeted to community health centers (CHCs) and a second to emergency departments (EDs). The toolkit was launched to the public with a press release on March 6, 2024.[7]

- In conjunction with the launch of the toolkit, we hosted a three-part webinar series that highlights key strategies to improve routine screening including opt-out testing, care team training and forming a strong referral network.[8] Since its launch, the toolkit has had over 22,000 pageviews, over 18,000 views of the launch series webinars and over 220 downloads of the PDF toolkit (as of January 31, 2025).
- In April 2024, we concluded a pilot of the routine screening toolkit with four EDs. The ED pilot cohort included: 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 of the quality improvement strategies outlined in the toolkit to implement in their emergency department to provide tangible feedback to the AMA on the effectiveness of these strategies and ease of implementation in addition to providing input overall on the toolkit itself.
- The pilot activities with the EDs, as well as our pilot in 2023 with CHCs, demonstrated that implementing programs to screen, diagnose, and connect patients to care for multiple infections is possible in EDs and CHCs. The AMA toolkit can help organizations implement screening programs successfully. Sites with leadership support, strong community ties, and efficient workflows succeeded in implementing the AMA toolkit, while technical and resource limitations posed implementation challenges.
- In September 2024, the AMA was awarded additional funding from the CDC to continue to increase awareness of and engagement with the HIV, STIs, Viral Hepatitis and LTBI Routine Screening Toolkit by hosting a Community of Practice to convene CHC and ED facilities interested in implementing strategies outlined in the toolkit to increase screening.
- The AMA has identified a group of approximately 20 CHCs and EDs from across the country to participate in this 6-month Community of Practice which is planned to take place in 2025. The AMA has also identified a group of national organizations who serve CHCs and EDs who are committed to helping promote the routine screening toolkit to their members during 2025.
- In addition to the work on the routine screening toolkit, the AMA has also received funding from the CDC to explore barriers in accessing preventive medications including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for HIV and doxycycline post-exposure prophylaxis (doxy PEP) for STIs. The

findings will inform the development of targeted education and resources to help improve access to these interventions.

E. 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, while recognizing that we must prioritize our efforts and that engagement 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. This year's campaign features a new PSA titled "Play Defense Against Flu" that leverages comedy to highlight how antibodies that develop after getting a flu vaccination work hard to protect oneself, loved ones and the community at large from the flu. Audiences are encouraged to gear up with a flu shot. The Get My Flu Shot campaign PSAs were 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 2024-25 flu campaign are as follows:

- The donated media value for the current Flu season reached $2.4 million. The most support has come from out of home (OOH – $1,103,913), closely followed by TV support ($1,017,100).
- A media tour was held on October 10, 2024, in English and Spanish, featuring spokespeople from the AMA and representatives from the CDC. Over 40 placements were secured across TV, radio, and digital, with a reach of 404 million digital impressions and 1.6 million broadcast impressions.
- A second media tour was held on December 9, 2024, in English and Spanish, with spokespeople from the AMA and representatives from the CDC. Over 90 placements across TV, radio, and digital were secured with a reach of 206.9 million digital impressions and 6.5 million broadcast impressions.
- We partnered with Influential for our trusted messenger activation on social media. The concepts include athletes showing how they keep themselves in top shape by prepping for flu. Data is incoming for the total impressions and estimated reach.
- PSA awareness is now 57 percent in Black and Hispanic respondents based off our most recent December 2024 tracking study.

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

The AMA's public health work has also been focused on 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 is 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-24 meeting, AMA has accomplished the following activities and developed a strategy to address climate change and health which was adopted at the I-24 HOD meeting:[9]

- The AMA has made climate change and sustainability education available via the Ed Hub™ from a variety of sources including the UC Center for Climate, Health, and Equity, Stanford Medicine, AMA Journal of

Ethics, the Journal of the American Medical Association (JAMA), and the American Public Health Association (APHA). For example:
    - In July 2024, the JAMA Network developed a short film on how operating rooms can be cleaner, featuring physician experts working to make operating rooms more sustainable.
    - On October 29, 2024, Clinically Significant™, an AMA Continuing Medical Education (CME) podcast covered the climate impacts of metered-dose inhalers.[10]
    - In February 2025, the AMA STEPS Forward® podcast released an episode presented the benefits of going green and effective strategies to implement sustainability throughout medical practices.
- AMA's Center for Health Equity released an episode as part of the Prioritizing Equity series featuring physicians and scholarly leaders advocating for equitable climate action to remedy the disproportionate burden of health harms climate crisis puts on historically marginalized communities (summer 2024).[11]
- 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 early summer 2025. 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 Update* podcast featured topics related to climate change impacts throughout the year to provide updates to physicians, including:
    - May 1, 2024, covered the recently released CDC heat risk initiative.
    - June 19, 2024, delved into the symptoms of heat stroke versus heat exhaustion that physicians should watch out for during 2024 heat waves.
    - June 26, 2024, focused on heat-related illnesses as many states across the country were experiencing record breaking heatwaves.
    - July 26, 2024, covered how the Earth was experiencing its hottest day (and year) on record.
    - January 15, 2025, discussed California wildfire smoke and how to improve air quality during wildfires.
- AMA developed and distributed a survey to physicians to assess perceptions on climate change and health, including the level of importance and relevance of climate change to physicians, understanding day-to-day effects of climate change that physicians may be experiencing or anticipating experiencing in the future, and exploring what the AMA's role should be in supporting physicians on climate change. Data analysis of survey results is ongoing.
- The AMA submitted an abstract to the APHA annual conference to be held in November 2025 to present findings from the survey distributed to physicians in December 2024 and will identify other avenues of dissemination for this information.
- The AMA continues to engage in the Medical Society Consortium on Climate and Health (MCSSH), which brings together associations representing over 600,000 clinical practitioners.[12] The AMA sits on the executive committee of this group. Additionally, the AMA was a sponsor of the MSCCH Annual Convention, held in March 2025 in Washington, DC.
- The AMA is a member and sponsor of the National Academy of Medicine Action Collaborative on Decarbonizing the Health Sector as a member of the Steering Committee and co-lead of the Health Care Delivery Workgroup. The Health Care Delivery Workgroup has been focused on three deliverables:
    - The *Building Momentum to Act on Health Care Decarbonization* webinar Series;
    - The *Clinical Environmental Sustainability Journey Map* to provide health care leaders and clinicians with actions they can implement to enable sustainable health care transformation of their organizations and practices.
    - A *Clinicians Key Actions Shortlist* on decarbonization that will pull key actions clinicians in the U.S. can take modeled after Choosing Wisely Canada's Climate-Conscious Recommendations designed to mobilize clinicians to stop or reduce low-value practices that harm the environment without compromising patient care.
- The AMA is represented on the APHA Center for Climate, Health, and Equity Advisory Board, which meets regularly to guide the overall strategic direction of APHA's Center for Climate, Health and Equity.
- Additionally, 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.[13] 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.

- In terms of advocacy efforts, the AMA joined with partners or submitted comments separately on the following:
    - AMA joined 85 other medical and public health organizations on January 25, 2025 in a letter to the Occupational Health and Safety Administration in support of their proposed standard on heat injury and illness prevention in outdoor and indoor work settings.[14]
    - AMA submitted a comment letter to CMS on June 10, 2024, in support of the Transforming Episode Accountability Model Decarbonization and Resilience Initiative, a voluntary effort designed to address threats posed by climate change to the nation's health and health care system by collecting, monitoring, and assessing, hospital carbon emissions and their effects on health outcomes, costs, and quality.

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.[15]

- The AMA continues to convene its Firearm Injury Prevention task force, which is charged with advising the AMA Board of Trustees on the role of organized medicine in firearm injury prevention and developing resources for physicians and trainees on firearm injury prevention to increase counseling of high-risk patients and awareness of available interventions.
- On June 10, 2024, the Firearm Injury Prevention task force hosted an educational session on *Health Care Strategies for Firearm Injury Prevention* at the House of Delegates meeting. Representatives from the Health Alliance for Violence Intervention, American Geriatric Society, Society of Critical Care Medicine, and American Pediatric Surgical Association. The session was recorded and shared on the AMA Ed Hub and YouTube channel.
- Task force members have participated in *AMA Update* video and podcast episodes on safe and secure firearm storage (featuring the American Academy of Pediatrics representative); the health system role in firearm injury prevention (featuring the American Pediatric Surgical Association representative), and Extreme Risk Protection Orders (featuring the Society of Critical Care Medicine representative and the Johns Hopkins Center for Gun Violence Solutions).
- The task force will be working to inform the development of resources for health care professionals to be featured on an expanded digital resource hub being developed with the Ad Council.
- On June 25, 2024, the AMA released a statement applauding the Surgeon General advisory on firearm violence as a public health crisis.
- On February 27, 2025, the Ad Council launched a new youth gun violence prevention initiative in collaboration with a coalition of health care and business leaders, including the AMA. This new effort is the first national cross-sector youth gun violence prevention campaign that aims to address the fact that firearm injuries have been the leading cause of death for children ages 1 to 17 for three consecutive years in the United States. The new public service announcement (PSA) is focused on parents and those with youth in their lives and encourages them to take action by visiting AgreeToAgree.org, where individuals can learn about gun violence and how to have conversations with their communities supported by conversations guides and resources.
- In conjunction with the Ad Council campaign launch on February 27th, 2025, Children's Hospital Association President and CEO Matthew Cook and American Medical Association CEO and EVP James L. Madara, MD authored an opinion piece published in Becker's Hospital Review titled, "*Hospitals and healthcare professionals must lead on firearm injury prevention to keep children and communities safe*."
- The AMA also partnered with the Ad Council on a video content series, featuring health care professionals speaking directly to other health care professionals on the responsibility and unique role they hold to help prevent firearm injuries through supportive conversations with their patients. The video series directs audiences to AgreeToAgree.org/HealthCare to learn more.
- On Thursday, March 6, 2025, AMA participated in a Washington Post Live conversation about how gun violence has impacted communities around the country, initiatives to find common ground, and efforts to bolster public safety and health.

- The AMA is also 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, American College of Emergency Physicians , American College of Physicians, American College of Surgeons, and the Council of Medical Specialty Societies.[16]
- In terms of advocacy, the AMA wrote a letter to the leadership of the Maine Judiciary Committee on April 4, 2024, expressing our support for LD 2283, legislation to establish crisis intervention orders to temporarily remove firearms from individuals deemed at high risk to themselves or others.

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 traditional borders. Blastomycosis, Histoplasmosis and Coccidioidomycosis are all fungal infections that have pushed through 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. Currently, H5N1 (avian influenza) is spreading through poultry and dairy farms with sporadic human cases and one death.[17] In addition, Clade I mpox (a more severe strain than was seen here in 2022) is spreading in part of Africa with a few cases occurring in the U.S. so far.[18] As 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 currently maintaining resources pages on mpox, H5N1, and COVID-19. We are working to create additional infectious disease related resources for physicians to be available on the AMA website to help ensure the continued availability of information should other sources not remain available.
- The AMA continues to release weekly *AMA Update* video and podcast episodes focused on public health topics, including the latest outbreak information. AMA YouTube subscribers have increased from 42,000 to 255,000 since the beginning of 2025.
- 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.[19]
- Over the last year, AMA has developed 7 *Stories of Care* podcast episodes exploring inequalities in infection prevention and control (IPC). The podcast series has featured episodes on improving hand hygiene compliance, IPC challenges within long-term acute care hospitals, how nurse-driven protocols can reduce HAIs, challenges with burnout in IPC teams, pediatrics and IPC challenges, how fostering resiliency improves retention in medical teams, and the importance of IPC research in medical training.
- The AMA funded seven state and specialty medical societies to develop training and IPC content for its membership and disseminate Project Firstline content with over 69,000 impressions in the first 6 months.
- In 2024, the AMA partnered with the CDC on two webinars addressing the measles resurgence and lower vaccine rates. The first, *Be on Alert for Travel-Related Measles*, featured a discussion on current measles epidemiology trends, measles recognition, travel-associated risks, core health care infection prevention measures and the importance of vaccination. The second webinar, *Measles: Stories From the Frontlines* featured speakers from the CDC, the Pediatric Pandemic Network, American Nurses Association, and American Academy of Pediatrics to bring their experiences caring for patients with measles.
- On August 6, 2024, AMA hosted a webinar to provide information on preparing for viral respiratory season including vaccination updates. Participants included CDC Director Mandy Cohen, MD, MPH and Demetre Daskalakis, MD, MPH.
- A six-part, ECHO-style tele-mentoring series ran from April through June of 2024 that explored the nuances of infection prevention in facility types outside of the acute care hospital. Settings included acute rehabilitation hospitals, ambulatory surgery centers, behavioral health units, post-acute long-term care facilities, dialysis facilities, and pediatric units.
- A CME module was published in 2024 that presents patient cases in a choose-your-own-adventure format outlining transmission-based precautions so that physicians and other health care professionals can recognize how to protect themselves in any situation.
- AMA is working with the American Society of Nephrology (ASN) to reach clinicians working in dialysis facilities. ASN is producing three hour-long webinars looking at preventing dialysis-related infections and how health care professionals can use social determinants of health to meet patients where they are. The first webinar was hosted in February 2025.

- On November 21, 2024, the AMA participated in a webinar with the CDC on *Leading the Way to a Healthier Winter: A Conversation for Clinicians on Flu, COVID-19, & RSV Vaccine.* The briefing covered new updates to vaccine recommendations for common respiratory viruses, the latest trends in respiratory illness, what to know about vaccination among health care professionals.

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 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.[20] The following summarizes the numerous resources created and work done on this topic:

- In 2024 the AMA completed the content and resource update for the physician education series module *Practical Guidance for Pain Management*. This content was made available to help physicians meet the DEA's MATE Act requirements, effective as of June 27, 2023.
- 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.[21]
- In 2024, the AMA developed additional episodes of the physician education podcast series on *The Opioid Overdose Epidemic*. Podcast episodes feature experts who shared relevant research, insights, and experience to help physicians of all specialties in addressing the opioid overdose epidemic. The four additional episodes include: *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.* As of December 2024, podcast engagement has risen annually from 7,930 downloads to 27,133 downloads, with a high interest in the following topics: *Opioid Prescribing and Appropriate Pain Management, Opioid Overdose Prevention, and Opioid Use Disorder Treatment.*
- In 2024, the AMA was awarded funding from the CDC to develop and implement a clinician toolkit focused on the recommendations and guiding principles of the 2022 Clinical Practice Guideline for Prescribing Opioids for Pain that is specifically tailored to community health centers (CHCs). During the two-year project period the AMA will partner with the National Association of Community Health Centers to develop an actionable toolkit resource for clinicians and will implement the toolkit resource in CHCs. The toolkit will provide an extensive, multidisciplinary, evidence-based educational experience for clinicians working in CHCs that is unique and sensitive to the needs of CHCs while also preparing them to serve as content experts and agents of change for their local healthcare communities regarding pain care.
- In November of 2024, the AMA released its 2024 Overdose Epidemic Report, showing progress in harm reduction services and policy promoting evidence-based care, but underscoring ongoing challenges as the nation's drug overdose epidemic continues.
- The AMA continues to participate as a member of the National Academy of Medicine 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.
- The AMA's Cannabis task force was established to inform and develop evidence-based education on cannabis. In 2024, the AMA developed and disseminated a podcast series on *Cannabis Education.* Episodes feature expert discussions and insights that can help physicians of all specialties understand cannabis and the health effects of cannabis use. Initial podcast episode course completions demonstrate a high interest in the topic *Cannabis and Pain Management.* Additional episodes with substantial engagement include *Cannabis Use and Psychiatric Disorders, Cannabis Pharmacology, How Addictive in Cannabis, Cannabis Use among*

Pregnant Persons, Preventing Cannabis Use among Minors, and What to Know about FDA-approved Cannabis-derived Products.

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, American Hospital Association , and Kaiser Permanente.[22] 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.

- 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 and take steps to join us by visiting the website, https://commonhealthcoalition.org/.
- On December 9, 2024, the Coalition announced its launch of the Inaugural Common Health Challenge to Champion Catalysts for Change, which will focus on Community Health Workers. As part of this initiative, the Common Health Coalition aims to advance meaningful Community Health Worker initiatives across the U.S. through partnership between health care and public health.[23]

In addition, the AMA took the following actions:

- In April of 2024, the AMA joined a letter to Congress urging the Labor, Health and Human Services, Education and Related Agencies appropriations bill for Fiscal Year (FY) 2025 to include funding to modernize and sustain our public health data infrastructure. The letter specifically requested at least $340 million annually for Public Health Data Modernization at the CDC.
- AMA released a leadership viewpoint in November of 2024, titled, *Building a robust public health system will benefit us all*.
- In March of 2025, the AMA joined a letter to the National Institutes of Health (NIH) expressing our appreciation for their longstanding commitment to funding scientific research that advances medical breakthroughs but noting that we are deeply concerned about the recently announced policy imposing a 15 percent cap on indirect cost recovery for NIH grants. The letter urges NIH to rescind this directive and instead work collaboratively to develop a solution that balances transparency, efficiency, and sustainability.

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 and 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 also made a financial contribution in 2024 to support the Coalition's work.
- 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 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 court ruled that the plaintiffs did not have standing to bring the lawsuit as they could not show a substantial risk that, in the near future, at least one platform will restrict their speech in response to the actions of a government defendant.

CONCLUSION

The current environment has elevated the critical importance of AMA's role of promoting and disseminating evidence-based public health policy and content. 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 2024 – March of 2025 related to the AMA's public health strategy. The AMA will likely need to increase efforts in these areas to maintain the organization as a trusted source of information for physicians and the public and to help protect the nation's public health infrastructure.

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26. USING PERSONAL AND BIOLOGICAL DATA TO ENHANCE PROFESSIONAL WELLBEING AND REDUCE BURNOUT

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOD ACTION: RECOMMENDATION ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy H-406.986

At the 2024 Annual Meeting, the House of Delegates (HOD) adopted Resolution 001, Resolved 2, "Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout," resulting in policy D-460.962, which directs our AMA to: "develop ethical guidelines on the collection, use, and protection of personal and biological data obtained to improve professional workforce wellbeing." This report is in fulfillment of this second directive from D-460.962.

BACKGROUND

Burnout represents a serious health crisis for physicians and other health care practitioners. Burnout compromises physician well-being and can negatively impact the quality of care that physicians provide to their patients [1]. The COVID-19 pandemic greatly exacerbated rates of burnout, with prevalence among physicians rising from 38.2 percent in 2020 to 62.8 percent in 2021 [2]. Drivers of burnout include increasing administrative burdens, lack of support from physicians' institutions and health care systems, changing political and legal landscapes, and other disruptions to the patient-physician relationship.

Since the height of the pandemic, the rate of burnout has trended downward, reaching below 50% in 2023 for the first time in four years [3]. Contributing to this decline are various health systems' initiatives to promote professional well-being, including hiring more staff, creating opportunities for coaching and leadership development, appointing wellness officers, and attempts to afford physicians greater flexibility and autonomy [4].

Though burnout is widespread throughout the medical profession, it is highly contextual and can manifest in different ways and to different extents depending on the individual and on the practice, institution, or health system in which the physician works. As such, health systems have increasingly turned to data to help guide and tailor their resources and efforts to support physician well-being, including using physician personal health information and biological data to inform interventions to reduce burnout [5]. However, how such physician information is collected and used raises ethical concerns.

The collection and use of physicians' personal health information and/or biological data raises ethical issues related to consent, privacy, confidentiality, and data security. Additionally, the collection and use of such data to help reduce burnout raises questions of accountability regarding who is ultimately responsible for implementing changes to reduce burnout, and risks shifting the focus of burnout reduction interventions from organizational strategies to individual physician behavioral changes, placing the burden of reducing burnout directly on physicians themselves.

DISCUSSION

There is general agreement within the medical profession that more needs to be done to reduce burnout and improve physician well-being. Because individual personal health information and biological data can provide valuable insights into physical and mental health, the collection and use of such data offer potential avenues to support the well-being of healthcare professionals, including the early identification of burnout and the development of evidence-based prevention strategies. The Internet of Things (IoT), which, in relation to health data, refers to a network of connected medical devices, such as wearable sensors that continuously capture various health metrics, including heart rate, blood pressure, sleep levels, and blood glucose levels, and transmit this information wirelessly in real time to a health care platform, has made it easier than ever to collect and monitor personal health information and has been promoted as a potential tool for combating physician burnout. Many physicians already use such wearable technologies as tools for self-monitoring and behavioral modification to promote well-being. However, while the collection and use of physicians' personal health information may help to identify and reduce burnout, doing so also poses serious concerns regarding efficacy, privacy, ethical data collection, and accountability.

Validity and Relevance of Collected Data

A primary concern raised with respect to relying on personal health information and/or biological data to reduce burnout is whether the observable data can accurately reflect the underlying subjective sense of well-being and mental health associated with burnout [6]. There are numerous factors associated with burnout, and the relationships between these factors are complex; furthermore, failure to accurately model this dynamic will inevitably result in a failure to adequately capture burnout. While substantive research has been done on physician burnout, there is no clear consensus on the definition or on how to assess it [7].

In their critique of the bio-psycho-social model of burnout (a framework that emphasizes the interconnectedness of biology, psychology, and social factors in human health and illness), Listopad et al identify a total of 40 factors related to burnout and conclude that the bio-psycho-social model is insufficient to identify all the factors and explain the pathogenesis of burnout; they propose extending the model to include spiritual and work culture dimensions that also impact burnout [8]. In addition to biological and psychological factors, which might be more readily detected via personal health information, Listopad et al show that socio-environmental factors, spirituality, and work culture also play an important role in the onset of burnout, which poses a problem for any data-based detection of burnout that fails to include these dimensions [8]. As Adler et al explain:

> Unlike illnesses solidly grounded in biological mechanisms, mental health and well-being is so fluid, psychosocial, and personal a construct that its indicators are necessarily up to individual interpretation—to monitor sleep and sociality in a potentially depressed person is not to monitor blood glucose in a person with diabetes. Removing a patient's ability to provide interpretation—their "right to self-presentation"—risks endorsing a fully data-centric perspective on well-being, one that might flatten necessary subjectivity [6].

Questions thus remain regarding what data best represents physician well-being and burnout, and how that data should be utilized.

Privacy and Confidentiality of Collected Data

Additional concerns regarding the collection and use of personal health information and/or biological data to reduce burnout center around issues related to privacy, confidentiality, data security, consent, and autonomy. There is general agreement among scholars that collecting and analyzing personal sensing data, the kind recorded by IoT technologies, poses real challenges to current norms around privacy, especially regarding the relationship between physicians and their supervisors [9]. Such challenges include concerns that personal data used to enhance professional well-being might blur the boundaries between work and life contexts, might recast physicians as patients, and that anonymity might be functionally impossible [6].

A central issue that emerges is how to balance respect for privacy with program utility. The challenge that arises is that anonymizing data is generally recognized as decreasing the utility of that data for improving individual-level well-being [6]. Research using protected health information (PHI) generally requires stricter privacy protections than de-identified data used for quality assessment (QI) or quality improvement (QI). However, even de-identified data risks re-identification, and it is highly likely that at small health care institutions anonymity of physician data would be

impossible. Furthermore, even if anonymity were possible, reporting on average values derived from de-identified datasets defeats the purpose of identifying individuals struggling with burnout.

While informed consent has been considered the key tool to remediate concerns regarding data privacy and confidentiality, Adler et al note with respect to personal sensing data, consent is not the same thing as an ongoing data use agreement [6]. An ongoing data use agreement (DUA) is a legal contract that outlines how specific data can be used and shared between parties, essentially governing the access and usage of sensitive information once it has been collected, whereas informed consent is a process in which individuals are given detailed information about a medical intervention or data collection activity before agreeing to participate. While an informed consent agreement primarily focuses on an individual's understanding of a medical intervention and their right to participate in it, a DUA focuses on the restrictions and permitted uses of collected data once it is shared. Such data sharing by physicians raises related concerns including who owns the data, how it is to be protected, and assurance that it will only be used to improve physician well-being.

Ethical Data Collection

Sharing personal health information, which could be collected even during non-working hours, potentially blurs the boundaries between physicians' work and personal lives and could be considered a violation of their privacy. Passive data collection and sharing also violates physicians' control over disclosure and may violate their autonomy. Any data collection program aimed at improving physician well-being would thus require an opt-out option, though it should be noted that opting out could negatively impact the overall quality of the data captured and negate any individual-level burn-out interventions. Relatedly, physicians should recognize that they have a duty to promote occupational health, though meeting this obligation should not come at the cost of violating their own individual rights.

To limit or reduce the risk of violations to physicians' privacy and autonomy, a crucial aspect of any such burnout reduction program would be a requirement to obtain the informed consent of any participating physicians, and would likely require the implementation of a DUA as well. In determining whether such a program would allow physicians to voluntarily opt-in or require them to voluntarily opt-out, it is important to acknowledge that, while opt-in policies may reduce the likelihood of participation and thus decrease the quality of any datasets obtained, opt-in policies do preserve the autonomy of physicians more than opt-out policies. Furthermore, it is imperative that anyone developing such programs recognize that the more data that is collected, the more personal the data is, and the more identifiable the information is all contribute to increasingly higher standards of physician protections that need to be in place.

Accountability

Current practices of physician performance profiling should be considered a warning sign about the likelihood that physician personal and/or biological data will be used only to improve physician well-being. The two main types of physician profiling in the US are clinical profiling and economic profiling, which examine a physician's treatments and outcomes of care or their financial performance (including cost and utilization of services), respectively. While, ideally, profiling should provide physicians with meaningful information on their clinical performance to help improve the quality of the services they provide, such profiling has largely become a tool for hospitals and other health care entities to control costs rather than as a method of measuring and improving quality of care [9]. Such developments raise questions about whether programs that use physician personal and/or biological data will actually use that data to serve physicians' best interests.

The focus on individual physician data also raises concerns regarding who may be seen as accountable for making improvements. The collection of individual physician data places an emphasis on individual behaviors rather than on institutional changes, which the consensus of researchers believe is necessary to significantly reduce burnout [10]. As Olson et al note, ameliorating burnout requires a systems approach and that organization-level interventions are far more effective at reducing burnout than individual-based interventions [10]. Rather than focusing only on programs aimed at promoting individual physician resiliency, Olson et al suggest that health care entities can reduce burnout by promoting workplace efficiency, supporting work-life integration, and granting greater physician control and autonomy over clinical decision-making and practice management in conjunction with promoting personal resilience [10].

Ultimately, collecting and using physician personal health information and/or biological data to improve physician well-being should only be implemented if the data is used solely to ameliorate stress-causing working conditions with clear accountability within the program regarding who is responsible for instituting those improvements. Any use of

physician personal health information or biological data for other ends, such as improving operational efficiency, especially any ends that could be perceived as retaliatory or perpetuating unjust biases, should be avoided.

RELEVANT AMA POLICY AND RESOURCES

It deserves to be noted that all physicians are at times likely to also be patients and suffer their own illnesses and injuries that require medical attention. In their capacity as patients, physicians enjoy the same rights as any other patient as outlined in the AMA *Code of Medical Ethics* (see Opinion 1.1.3, "Patient Rights") [11]. Like any patient, they are entitled to receive quality care (Opinion 1.1.6), to informed consent (Opinion 2.1.1), to have their privacy respected (Opinion 3.1.1), and to have their de-identified data handled with care (Opinion 3.3.4) [12-15].

In their capacity as physicians, they also have obligations to practice continual self-awareness and self-observation to ensure that they are competent to practice medicine (Opinion 8.13), to strive to promote their own health and wellness (Opinion 9.3.1), and to intervene with respect and compassion in the event that they discover a colleague is not able to practice safely (Opinion 9.3.2) [16-18]. Any programmatic collection and use of physician data, especially that which might be considered private health information, must adhere to the ethics guidance outlined in the AMA *Code of Medical Ethics*.

The collection and use of physician data raises several concerns, including issues related to privacy and consent, access and appropriate use, and the potential for coercion and discrimination. To protect physicians whose data is collected and used to improve physician well-being, it is therefore crucial that, in addition to the AMA *Code of Medical Ethics*, the AMA Privacy Principles be followed [19]. These principles, derived primarily from AMA HOD policy, were developed to provide individuals with data rights and protections from data holders other than HIPAA-covered entities. These guidelines provide broad guardrails to address individual rights, equity, data stewardship and related entity responsibilities, appropriate applicability, and enforcement. Any programmatic collection and use of physician data to improve well-being must also recognize that different specialties will likely require custom solutions, that different sized institutions will likely require tailored solutions, and that, generally, one-size-fits-all interventions are likely to be ineffective. Lastly, the collection of physician data is likely to be insufficient on its own to reduce burnout—physician engagement and collaboration will be crucial to successfully operationalize the collection and use of physician data to reduce burnout and improve physician well-being.

CONCLUSION

As technologies advance, the workplace is becoming increasingly quantified, with data analytics being used to identify opportunities for optimization and to improve productivity. The implementation of new tools for the collection and use of data is remaking the boundaries of appropriate information flows and will continue to have a growing impact on physicians and the practice of medicine. The collection and use of physicians' personal health information and/or biological data has the potential to help reduce burnout and improve physician well-being; however, the practice also creates several ethical dilemmas and should not be viewed as a panacea.

Further research is needed to better capture and define the lived experiences of burnout and well-being. Prior to implementation, policy protections should be developed to hold supervisors and administrators accountable and ensure that such programs are truly physician-centered and do not place the onus of preventing burnout on those suffering from it. Additionally, new policies and relational norms will need to be developed to protect physician data, prevent abuse of the power differential between data subjects and the data recipients, and ensure that such data is used solely for improving physician well-being and not in any way that could be perceived as retaliatory [6].

In light of these observations, the medical profession may consider collecting physician data to improve well-being but should do so with extreme caution. Furthermore, when collecting physician data, it is imperative that the AMA *Code of Medical Ethics* and AMA Privacy Principles be followed.

RECOMMENDATIONS

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

1. With the aim of promoting physician well-being in the workplace, physician personal health information and/or biological data should be:

a. Collected only if evidence supports that the specific data being collected is minimized to only that which is relevant and necessary to the development of interventions which promote physician well-being and reduce professional burnout;

b. Collected only if physicians are informed whether the data is directly or indirectly identifiable;

c. Collected only if physicians have the ability to opt-in or opt-out without retribution, penalty, or direct or indirect coercion;

d. Collected only if physicians are able to provide informed consent prior to data acquisition and use;

e. Collected only if physicians retain the option to opt-out at any time;

f. Used only to ameliorate burnout-inducing working conditions.

2. Any use of physician personal health information or biological data that is retaliatory or that perpetuates unjust biases should be avoided and prohibited.

3. Any entity that collects physician personal health information or biological data must have transparent policies and procedures for secure data storage as well as its storage duration and deletion protocols.

4. The second directive of Policy D-460.962 be rescinded having been accomplished by this report.

Fiscal Note: Less than $500

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

Informational report; no reference committee hearing.

HOD ACTION: FILED

At the 2024 Interim Meeting, the House of Delegates adopted the following recommendations in Board of Trustees Report 16, AMA Reimbursement of Necessary Business Meeting Expenses for Delegates and Alternates (Policy D-600.951):

1. Our American Medical Association will issue a report at the 2025 Annual Meeting, and each meeting thereafter, identifying the number of delegates and alternate delegates supported by the grants and the total amount provided under our AMA House of Delegates Emergency Assistance Program.
2. Our AMA will provide the House of Delegates with reports on a regular cadence detailing ongoing work regarding House of Delegates meetings to mitigate costs, explore solutions, and maintain participation while reducing the financial burden on all parties over the long term.
3. Our AMA will not reduce by one day the 2025 Annual and Interim Meetings and will issue a report for consideration at the 2025 Annual Meeting outlining details for potential changes to the length and format of future House of Delegates meetings.

This report is presented as information to the House of Delegates.

In November 2024, the Board of Trustees established an Emergency Assistance Pilot Program (EAP) to support state medical associations and national medical specialty societies experiencing financial hardship. The program, limited to meetings of the House of Delegates (HOD), will be in effect for the Annual and Interim meetings in 2025 and 2026. Information on applying and qualifying for the program, including data about delegate apportionment was sent to the Chief Executive Officer/Executive Director of each organization seated in the House of Delegates. Societies must apply annually; if approved, the emergency assistance grant will apply to both the Annual and Interim meetings for that calendar year.

In its initial cycle, twenty-four societies inquired about the program, and twenty-one submitted applications. Two societies did not meet the two percent of revenue threshold for delegate and alternate delegate expenses, and one was unable to provide the necessary tax documentation. Ultimately, 18 societies qualified for assistance, covering approximately 300 delegates and alternates -- including some regional medical student delegates and sectional resident and fellow delegates. The AMA will disburse 50 percent of the emergency grant assistance in advance of the meetings with the remainder paid after attendance has been confirmed.

While the AMA has restored the original meeting schedule for the HOD and opted not to shorten the 2025 Annual and Interim Meetings by one day, the Board has tasked the Council on Long Range Planning and Development with preparing a comprehensive report. This report will explore potential changes to the length, format, and structure of future HOD meetings and will be submitted to the Board for review and further consideration.

The Board of Trustees will provide the House of Delegates with a future report summarizing these ongoing efforts to mitigate meeting-related expenses, ensure broad participation, and responsibly steward AMA resources over the long term.

28. SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES - FIVE-YEAR REVIEW

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOD ACTION: RECOMMENDATION ADOPTED
REMAINDER OF REPORT FILED

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) required to submit information and materials for the 2025 American Medical Association (AMA) Annual Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process."

Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of professional interest medical associations and national medical specialty organizations is also required as set out in AMA Bylaw 8.2, "Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations."

The following organizations were reviewed for the 2025 Annual Meeting:

American Academy of Otolaryngic Allergy
American Association for Geriatric Psychiatry
American College of Legal Medicine
American College of Mohs Surgery
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Preventive Medicine
American College of Radiology
American College of Surgeons
American Society of Breast Surgeons
American Society of Retina Specialists
American Vein and Lymphatic Society
Heart Rhythm Society
Society of Hospital Medicine
Undersea and Hyperbaric Medical Society

The American Association of Plastic Surgeons, American Society for Metabolic and Bariatric Surgery, and American Society of Cytopathology were also reviewed at this time because they failed to meet the requirements in June 2024 and were granted a one-year grace period.

Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that: American Academy of Otolaryngic Allergy, American Association for Geriatric Psychiatry, American College of Legal Medicine, American College of Mohs Surgery, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Preventive Medicine, American College of Radiology, American College of Surgeons, American Society of Breast Surgeons, American Society of Retina Specialists, Heart Rhythm Society, and Undersea and Hyperbaric Medical Society meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that the American Association of Plastic Surgeons, American Society for Metabolic and Bariatric Surgery, and American Society of Cytopathology met all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that the American Vein and Lymphatic Society and Society of Hospital Medicine did not meet all guidelines and are not in compliance with the five-year review requirements of specialty organizations represented in the AMA HOD.

RECOMMENDATIONS

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

1. The American Academy of Otolaryngic Allergy, American Association for Geriatric Psychiatry, American Association of Plastic Surgeons, American College of Legal Medicine, American College of Mohs Surgery, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Preventive Medicine, American College of Radiology, American College of Surgeons, American Society for Metabolic and Bariatric Surgery, American Society of Breast Surgeons, American Society of Cytopathology, American Society of Retina Specialists, Heart Rhythm Society, and Undersea and Hyperbaric Medical Society retain representation in the American Medical Association House of Delegates.

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in the AMA Bylaw B-8.5, the American Vein and Lymphatic Society and Society of Hospital Medicine be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership.

Fiscal Note: Less than $500

APPENDIX

Exhibit A - Summary Membership Information

Organization	**AMA Membership of Organization's Total Eligible Membership**
American Academy of Otolaryngic Allergy*	209 of 985 (21%)
American Association for Geriatric Psychiatry	7,122 of 35,038 (20%)
American Association of Plastic Surgeons*	153 of 784 (20%)
American College of Legal Medicine*	94 of 286 (32%)
American College of Mohs Surgery	252 of 1,084 (23%)
American College of Obstetricians and Gynecologists*	12,471 of 42,173 (29%)
American College of Physicians*	24,924 of 79,204 (31%)

American College of Preventive Medicine*	376 of 1,394 (28%)
American College of Radiology*	7,122 of 35,038 (20%)
American College of Surgeons	11,471of 53,116 (21%)
American Society for Metabolic and Bariatric Surgery	381 of 1,765 (21%)
American Society of Breast Surgeons	479 of 2,441 (20%)
American Society of Cytopathology*	340 of 1,197 (28%)
American Society of Retina Specialists	467 of 2,137 (21%)
American Vein and Lymphatic Society	No data submitted
Heart Rhythm Society	1,524 of 3,994 (38%)
Society of Hospital Medicine	2,169 of 11,881 (18%)
Undersea and Hyperbaric Medical Society	89 of 424 (20%)

* *Represented in the House of Delegates at the 1990 Annual Meeting*

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.

2. The organization must:

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

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

   (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
   (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.

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

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

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

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

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

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

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

Exhibit C

8.2 **Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations.** Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

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

8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.

8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.

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

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

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.5 **Periodic Review Process.** Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society, or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

8.5.1 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting or may take such other action as it deems appropriate.

8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of

Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.