Reference Committee F

Report(s) of the Board of Trustees

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23 Financial Assistance to Facilitate Attendance at MSS Meetings
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REPORT OF THE BOARD OF TRUSTEES

B of T Report 01-A-25

Subject: Annual Report

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee F

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.

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AMA
AMERICAN MEDICAL ASSOCIATION

WHY WE FIGHT

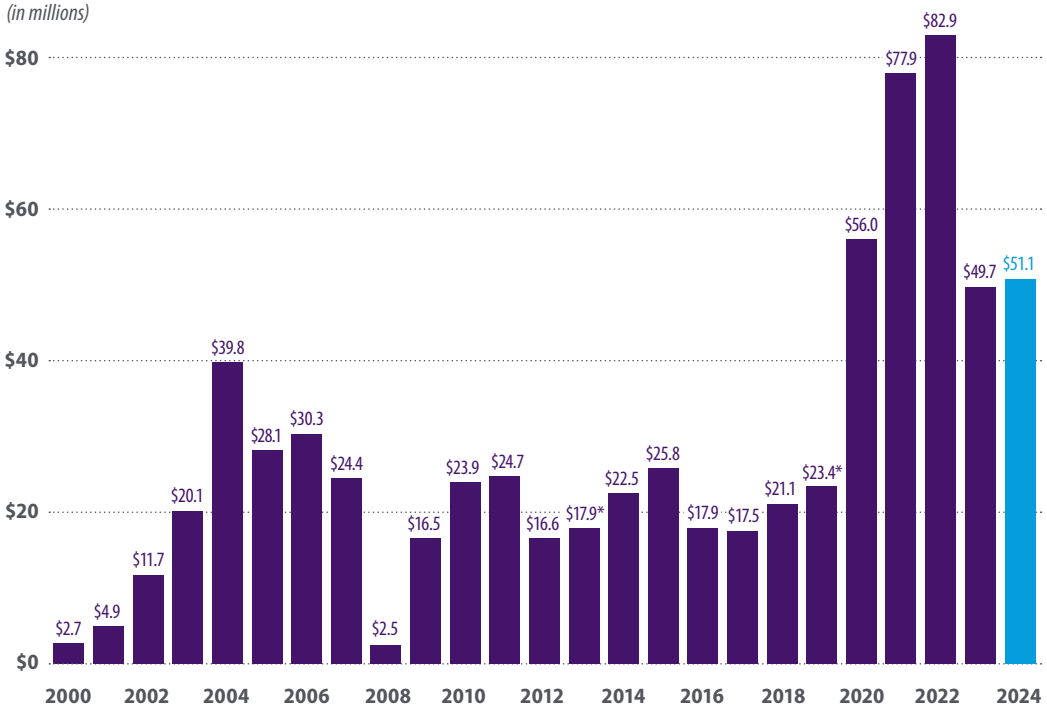
2024 ANNUAL REPORT

Financial highlights

(Dollars in millions)	2024	2023
Revenues	$ 513.2	$ 495.1
Cost of products sold and selling expense	23.7	27.8
General and administrative expenses	434.3	412.5
Net operating results	51.1	49.7
Non-operating items	74.1	101.7
Changes in defined benefit postretirement plans, other than periodic expense, net of tax	2.0	(17.3)
Change in association equity	127.2	134.1
Change in association equity – donor restricted	0.1	(0.1)
Change in total association equity	$ 127.3	$ 134.0
Association equity at year-end	$ 1,150.7	$ 1,023.4
Employees at year-end	1,331	1,314

Association operating results

(in millions)



* Pro forma operating results: 1) 2013 excludes $33 million in nonrecurring charges relating to AMA's headquarters relocation and 2) 2019 excludes $36.2 million noncash pension termination expense reclassification from non-operating results.

2020 through 2022 results were impacted by a lack of travel due to the pandemic, as well as a hiring freeze and subsequent tight labor market. These savings were temporary in nature.

Letter to stakeholders

During an important election year, in which the public's attention was often frayed, the American Medical Association remained hyper focused on priorities critical to supporting and strengthening our nation's physician workforce and improving the lives of patients. **This is why we fight**.

Grounding our work in the Principles of Medical Ethics and the policies of the AMA House of Delegates, 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.

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—that are expected to save physician practices billions over the next decade.

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

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

Support for physician mental health and well-being expanded in 2024 as the AMA led, funded or contributed to 38 research projects to address burnout, promote digital health solutions and 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.

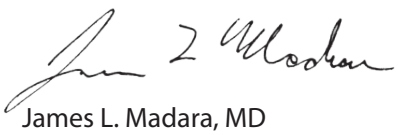
In the courts, the AMA was a critical voice for physicians and organized medicine on a broad range of public health issues, including restricting access to e-cigarettes, tougher regulation of unlicensed and untraceable "ghost" guns, and expanding access to care. In addition to defending physicians from 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 continued its work to ensure the physician's perspective is represented in the design, implementation and evaluation of new health care technologies, while helping physicians make sense of the risks and opportunities of augmented intelligence (AI) in medicine.

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

Michael Suk, MD, JD, MPH, MBA
Chair, Board of Trustees

Madelyn E. Butler, MD
Finance Committee Chair, Board of Trustees



James L. Madara, MD
CEO and Executive Vice President

Why we fight

As the unified voice for physicians from every state and every specialty, the AMA *can* create a better future for patients, the practice of medicine and the health care system. By working together, we can make it happen. **This is why we fight**.

While 2024 had its challenges, it also had its victories. The AMA continued to advocate for physicians and patients and saw progress in each of our top priorities:

- Reforming Medicare payment
- Fixing prior authorization
- Fighting scope creep
- Reducing physician burnout
- Making technology work for physicians

This year's report highlights these accomplishments and much more as we continue our work to remove obstacles that interfere with patient care.

#FightingForDocs

Reforming Medicare payment

33% decline in Medicare physician pay since 2001

In 2024 our work to reform the Medicare physician payment system continued. Fueled in part by the AMA garnering more than 550,000 contacts to Congress as part of our "**Fix Medicare Now**" grassroots campaign, the AMA spurred legislators and policymakers to work in bipartisan fashion to introduce two important pieces of legislation:

- 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

The AMA will not stand for practices needing to close and patient access to care being threatened. Medicare payment reform will remain the AMA's top advocacy priority until meaningful reforms are achieved.

"Through our efforts, legislators in Congress are listening, and there is bipartisan support for a **need to fix the Medicare payments problem.**"

Bruce A. Scott, MD
AMA president

Fixing prior authorization

64% of physicians report that prior authorization can **destabilize a patient** whose condition was previously stabilized on a specific treatment.

When a sustained, coordinated push was needed to take on prior authorization issues, the AMA leaned into its "**Fix Prior Auth**" grassroots campaign. This, combined with powerful AMA advocacy applied pressure on federal and state legislators and policymakers to act in passing meaningful prior authorization reforms that included:

- The Centers for Medicare & Medicaid Services (CMS) released final regulations to cut patient care delays and electronically streamline the prior authorization process for physicians—**saving physicians billions over 10 years according to CMS.**
- More than a dozen states enacting prior authorization reform laws guided and supported by the AMA and multiple state medical associations.

The AMA will continue to advocate for prior authorization reforms and to challenge insurance companies to eliminate care delays, patient harms and practice hassles.

"**The AMA is the voice of physicians to legislators, to regulators, to insurance companies.** There's no one else who speaks with such a powerful megaphone on prior authorization."

Jordan Warchol, MD, MPH
AMA member

Fighting scope creep

95% of surveyed patients want physicians to be involved in their health care diagnosis and treatment.

The AMA worked alongside state medical associations from across the country to oppose inappropriate scope expansions in more than 40 states in 2024. Much of the success was driven by the **AMA Scope of Practice Partnership**—an initiative that has provided millions in grants since its inception—and the remarkable expertise and dedication of the **AMA Advocacy Resource Center** lawyers and staff.

The AMA delivered concrete results including the defeat of more than 80 bills across the country that, if passed, 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

Expanding non-physicians' scope of practice puts patients at risk. The AMA will vigorously defend the practice of medicine and advocate for physician-led team-based care, where the complementary skill sets of all health care professionals provide the best possible care to patients.

"The AMA Scope of Practice Partnership has been invaluable to my work fighting inappropriate scope of practice legislation in South Dakota."

Mary S. Carpenter, MD
AMA member

Reducing physician burnout

More than 45% of physicians are experiencing symptoms of burnout.

As the leader in physician well-being and innovative burnout research, the AMA is fighting against physician burnout, and in 2024 we made significant progress.

As of the end of 2024, the AMA had helped 34 licensure boards—including 29 medical boards—and more than 425 hospitals and health systems revise their licensing or credentialing applications to remove intrusive mental health questions and stigmatizing language. This important step forward could only have happened through ongoing partnerships with organizations like the Dr. Lorna Breen Heroes' Foundation.

Our accomplishments didn't stop there. In 2024 the **AMA's Joy in Medicine™ Health System Recognition Program** recognized 62 health systems that met the evidenced-based criteria demonstrating their commitment to organizational well-being—these additions brought the list of currently recognized organizations to 130 across 35 states.

The AMA will continue to address and combat the drivers of physician burnout so that physicians receive the support they need to thrive.

"Physicians deserve to practice in an environment where they can take care of their patients *and* take care of themselves."

Claude Brunson, MD, MS
AMA member

Making technology work for physicians

Technology should be an asset to physicians and patients—not a burden.

Technology is engrained in virtually all aspects of health care, yet it can feel cumbersome, costly and inefficient when put into practice. From AI implementation to EHR usability, the AMA is dedicated to ensuring technology works *for* physicians—not the other way around.

In 2024, underscoring its commitment to making sure the physician voice is ever-present as AI in health care expands, the AMA released "**The emerging landscape of AI in health care**," a report that provides an overview of current and future AI use cases, potential applications, opportunities and risks.

The AMA will fight to make sure the physician voice is integrated into the creation and refinement of all health care technology.

"**Physicians need to be involved in developing new technologies** because we are the ones who use them. The AMA makes sure we have a seat at the table."

Joshua Lesko, MD
AMA member

Additional 2024 highlights

As physicians' powerful ally in patient care, the AMA focuses on providing solutions to issues that matter most to physicians. Care delivery, practice efficiency support, educational resources, representation in the courts, improving health outcomes and so much more—across a broad range of challenges and opportunities, the AMA celebrated numerous successes.

From the U.S. Supreme Court to state courts, the AMA was a powerful, unifying voice for physicians and organized medicine. In addition to leading the **antitrust lawsuit** against MultiPlan, the data analytics company that allegedly conspired with major health insurers to force physicians to accept lower reimbursement rates, the AMA filed *amicus* briefs on a broad range of public health issues, including e-cigarettes, firearm safety and access to care.

More than 1.1 million physicians and other licensed/credentialed health care professionals benefited from the AMA and partnering organizations' efforts into ending stigmatizing questions on medical licensing and credentialing applications.

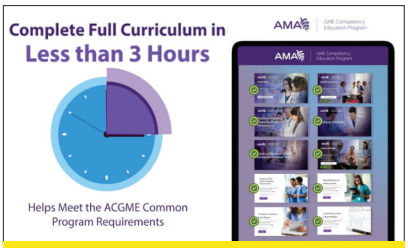
The AMA received a record-breaking number of abstract submissions—1,300—for the **AMA Research Challenge**—the largest national, multi-specialty medical research conference for medical students and residents to showcase and present research featuring a $10,000 grand prize, presented by Laurel Road.

Following the Change Healthcare cyberattack, which demonstrated the need to enhance cybersecurity in health care, the AMA took a leading role in advocating at all levels of government and across the payer community to **strengthen cybersecurity** and find solutions that will allow physician practices to maintain financial stability.

31M the number of readers, listeners and viewers who consumed AMA digital content
(excluding JAMA® and AMA Ed Hub™)

The AMA partnered with more than 100 health systems to identify and assess system-level drivers of well-being through the **AMA's Organizational Biopsy® validated well-being assessment**.

The AMA concluded the 2024 AMA ChangeMedEd® Innovation Grant Program that awarded grants to 13 organizations whose work is part of a two-year effort that is culminating with the launch of the AMA's **new precision education portfolio** in 2025.



The AMA launched our **Foundations of Quality Improvement and Patient Safety (QIPS) curriculum** through our GME Competency Education Program (GCEP). The curriculum has already received a Brandon Hall Group award for Excellence in Online Courses and a Digital Health Award for digital health/media publications in health education. This is the fifth time that the GCEP program has taken home a Digital Health Award.

The AMA developed more than 90 new or updated **AMA STEPS Forward® resources** including toolkits, webinars and podcast episodes focused on improving practice efficiency, preventing physician burnout and creating the organizational foundation for joy in medicine.

The AMA helped physicians stay on top of rapidly evolving health care technology by presenting several webinars including "Digital empathy," "The human factor in solving problems" and "Navigating AI in health care."

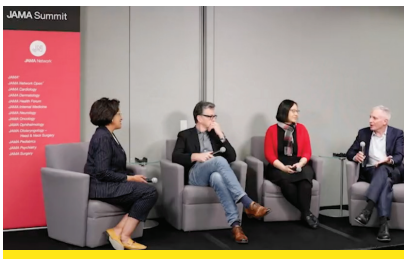
3.3M physicians and health care team members have used AMA STEPS Forward® since 2015.

AMA Ed Hub™, the AMA's online education platform, continued to experience high engagement:

8K+	475K+	4M	600K
education activities	registered users	visitor sessions	courses completed

The AMA reaffirmed its commitment to health equity by updating our multi-faceted 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.

The AMA conducted research exploring the role of Current Procedural Terminology (CPT®) in value-based care. The effort identified crucial ways to help ensure the CPT code set remains a crucial resource as **value-based care** continues to evolve in health care delivery.



JAMA® hosted the second annual ***JAMA* Summit™**, convening leaders from across sectors and around the world to discuss critical issues in medicine and health care. This year's event focused on the integration of AI in clinical medicine.

JAMA+ AI launched as a premier resource for authors and readers seeking the latest science and commentary on AI and its application to medicine and public health.

An additional 281 health care organizations used **AMA hypertension solutions** to help their physicians and care teams improve blood pressure control in patients. Through our collaboration with these organizations, we reached more than 2.5 million patients with hypertension.

To expand insight into burdensome 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 levels.

In collaboration with more than 20 organizations, the AMA hosted **two National Health Equity Grand Rounds that reached over 24,000 viewers** and featured more than a dozen national experts who discussed transformative change in health care.

The AMA launched **VeriCre™**, to streamline the credentialing process and reduce redundancy for physicians, hospitals and health plans, helping patients to receive care sooner.

14B media impressions on priority topics such as Medicare payment reform

The AMA generated more than 14 billion media impressions on priority topics with 3.8 billion on Medicare payment reform—nearly double the total from 2023.

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 HIV, STIs, viral hepatitis and latent tuberculosis**—this in response to rising rates of sexually transmitted infections and viral hepatitis across the United States.

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 United States.

The AMA won the American Association of Medical Society Executives (AAMSE) **Profile of Excellence Award** for its communications campaign to "Protect Medicine from Government Interference."

The AMA was recognized as "Best Customer Experience Team of the Year" with the "Best Employee-Driven Customer Experience" at the 2024 U.S. Customer Experience (CX) Awards, based on the AMA's use of data, design tools and best practices to make accessing and consuming AMA products and services easy for our members.

Management's discussion and analysis

Management's discussion and analysis

Introduction

The objective of this section is to help American Medical Association (AMA) members and other readers of our financial statements understand management's views on the AMA's financial condition and results of operations. This discussion should be read in conjunction with the audited consolidated financial statements and notes to the consolidated financial statements.

Improving the health of the nation is at the core of the AMA's work. As the physicians' powerful ally in patient care, the AMA delivers on this mission by representing physicians with a unified voice in courts and legislative bodies across the nation, removing the largest governmental and private sector obstacles that interfere with optimal patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care and training the leaders of tomorrow. AMA's strategic arcs are supported by improving health outcomes, lifelong medical education and enhancing physician professional satisfaction and practice sustainability. Our advocacy, health equity and innovation initiatives function as accelerators across all arcs. AMA's foundation is built on science, membership, financial performance, marketing and communication, and talent and engagement.

2024 priorities are focused on five key goals to rebuild health care so that it works better for physicians and all those they serve: 1) reforming Medicare payment to promote thriving physician practices and innovation; 2) fixing prior authorization to reduce the burden on practices and minimize care delays for patients; 3) promoting physician-led care as health care teams working together—with physicians in the lead—is critical to having the best and safest outcomes for patients; 4) reducing physician burnout and addressing the stigma around mental health; and 5) working to ensure physician voices are integrated into the creation and refinement of all medical technology to make technology an asset to physicians, not a burden.

For example, through research, advocacy and education, the AMA continued to defend the practice of medicine against scope of practice expansions that threaten patient safety. AMA efforts helped deliver concrete results in protecting patients from inappropriate scope of practice expansions, including the defeat of over 80 problematic bills. Spurred by over 550,000 contacts to Congress as part of the AMA's "Fix Medicare Now" grassroots campaign, policymakers are acknowledging the Medicare physician payment crisis and acting toward making permanent payment system solutions in line with AMA recommendations.

The results for 2020 through 2022 were dramatically impacted by the COVID-19 pandemic. Early in 2020, the AMA, like all other organizations, recognized that there was substantial uncertainty about the effects and risk of COVID-19 on our funding, financial condition, and results of operations. As a result, AMA took steps to ensure that programmatic activities and employment levels would be protected during a sustained pandemic, knowing the potential for economic uncertainty. AMA lifted a freeze on hiring in the spring of 2021, but the level of open positions remained high through 2022 as the job market was very tight. Vacancies and limited travel for most of the three years garnered substantial savings that were temporary in nature resulting in unusually high operating income for AMA. Results began to normalize in 2023 and 2024, although better than expected revenue growth and a slower ramp up in operating expenses than expected continue to drive a higher level of net operating income than in the past.

The AMA is committed to its responsibility of ensuring that the organization focuses its finite resources on strategic arcs, accelerators and core mission activities while improving the quality and breadth of products and services for physicians and medical students. Our physicians' and medical students' voices are central to AMA's overall success.

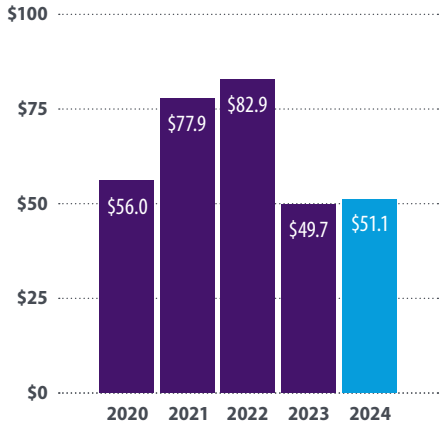
The following pages discuss the 2024 consolidated financial results as compared to 2023. Additional detailed discussion of operating unit results is included in the section titled "Group Operating Results."

Consolidated financial results

Results from operations

Net operating results

(in millions)



As noted above, the hiring freezes and work from home during 2020 through 2021 and the unusually tight labor market that adversely impacted hiring and limited travel and in-person meetings through the first half of 2022 were major factors in spending levels running substantially less than budgets. Spending levels began to normalize in 2023 although open positions remained higher than previously experienced.

In 2024, revenue growth more than offset a continued increase toward normalized spending levels, resulting in a slight improvement in operating results when compared to 2023.

Revenues

In 2024, total revenue increased $18.1 million over the prior year. Continued growth in AMA's royalties and increased investment income were partially offset by declines in publishing advertising, coding book sales and insurance commission revenue.

Consolidated investment income, which is dividend and interest income, net of management fees, increased in 2024, impacted in large part by higher interest rates and a larger invested asset base. Market gains or losses are not included in investment income and are reported as non-operating results.

The number of AMA dues paying members increased by 3.1 percent in 2024, the 13th year of growth in the past 14 years. During that 14-year period, AMA dues paying membership increased by over 89,000. Dues revenue declined 2.4 percent in 2024 as growth in lower dues paying categories such as group memberships and sponsored memberships partially offset the decline in individual direct member categories.

Most other revenue categories were largely unchanged for the year.

Cost of products sold and selling expenses

All variable expenses related to production, distribution and sale of periodicals, books, coding products and licensed products are included in the cost of products sold and selling expense categories. Examples include paper, sales commissions, promotional activities, distribution costs and third-party editorial costs.

In 2024, cost of products sold and selling expenses decreased $4.1 million from the prior year. In late 2023, Publishing eliminated distribution of print journals to a controlled population of physicians who were included in measuring journal readership scores, a key indicator for ad placement. This change substantially reduced production and distribution costs in 2024 and partially offset the historical advertising revenue decline. A reduction in coding book sales volume also led to a reduction in related production and selling expenses.

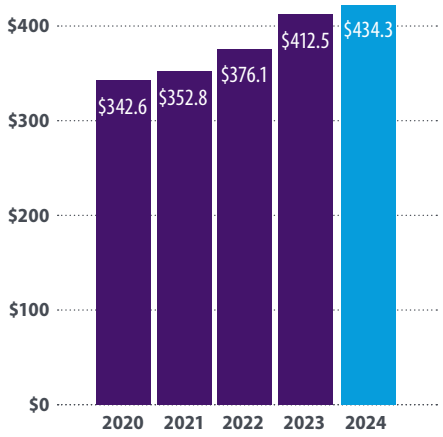
Contribution to general and administrative expenses

Cost of products sold and selling expenses are deducted from revenues to determine the amount of money available for the general and administrative expenses of the organization. Contribution to general and administrative expenses measures the gross margin derived from revenue-producing activities.

The contribution to general and administrative expenses increased $22.2 million to $489.5 million in 2024, a combination of the $18.1 million revenue improvement coupled with the savings from eliminating publishing-controlled circulation and lower production costs from reduced coding book sales.

General and administrative expenses

(in millions)



General and administrative expenses rose $21.8 million in 2024, or 5.3 percent, when compared to 2023. This was substantially less than the $48.9 million budgeted increase for 2024, with over $27 million in savings related to technology, marketing, professional services, and travel impacting results.

Compensation and benefits increased $17.4 million in 2024, up 6.6 percent. Compensation, including temporary help, was $7.9 million higher in 2024, a 3 percent increase, which was a function of annual merit increases, as expense for filling open positions was largely offset by savings from terminations. Fringe benefit costs increased $4.7 million in total primarily due to higher medical, 401(k) plan and payroll tax expenses. Incentive compensation increased $4.6 million as key performance indicators were achieved or exceeded in 2024.

Occupancy costs were down $1.4 million, driven by a reduction in depreciation as certain assets acquired during the move to new headquarters were fully depreciated. In late 2022, AMA exercised a contraction option in the main headquarters lease whereby AMA relinquished one full floor of office space beginning in 2023 upon payment of a termination penalty. In late 2023, AMA negotiated an extension of the current headquarters lease in return for future contraction options and lease incentives. The impact will be amortized over the life of the lease and there was largely no change in rent expense in 2024.

Travel and meeting costs increased by $0.5 million in 2024 due to inflationary cost pressures. Technology costs were largely unchanged. As more technology moves to the cloud, costs associated with the technology platforms will be reflected in operating expense instead of capitalized as an asset and depreciated. This model has the benefit of reducing the need for in-house development expertise but also exposes AMA to more price risk from vendors.

Marketing and promotion costs increased $3.4 million in 2024, as Advocacy expanded its grassroots and media campaign activity on Medicare payment reform.

Outside professional services increased $5.5 million in 2024, primarily in Health Solutions, Strategic Arcs, and Enterprise Planning, led by a $2 million increase in Health Solutions for strategy, market research and platform development as well as over $1 million in Strategic Insights and Planning for research on health care organizations and AMA's mission impact.

Other operating expenses declined $4.1 million in 2024 due to the absence of a software write-off associated with exiting the Integrated Health Model Initiative and costs related to liquidating a Health2047 affiliate in 2023.

Operating results before income taxes

The AMA reported $55.2 million in pre-tax operating income in 2024 compared to $54.8 million in 2023. The current year results include over $18 million in revenue growth that was largely offset by higher spending, the latter a continuation toward normal budgeted expense levels.

Income taxes

Taxes decreased $1 million in 2024 when compared to 2023, reflecting lower taxable income in one of the subsidiaries.

Net operating results

Net operating income was $51.1 million in 2024 compared to $49.7 million in 2023, as revenue growth was largely offset by higher spending.

Non-operating items

The AMA reported a $79.7 million gain in the fair value of its portfolio during 2024. Additional portfolio performance information is discussed in the group operating results section.

As a result of an accounting standard adopted in 2019 for postretirement benefit plans, non-operating results include $5.7 million and $3.9 million in postretirement plan interest expense and recognized actuarial losses and gains for 2024 and 2023, respectively.

Revenue in excess of expenses

Revenues exceeded expenses by $125.2 million in 2024, a combination of $51.1 million in operating income, a $79.7 million gain in fair value in the portfolio and $5.6 million in other non-operating expenses. In 2023, revenues exceeded expenses by $151.4 million, a combination of $49.7 million in operating income, a $105 million gain in fair value in the portfolio and $3.3 million in other non-operating expenses.

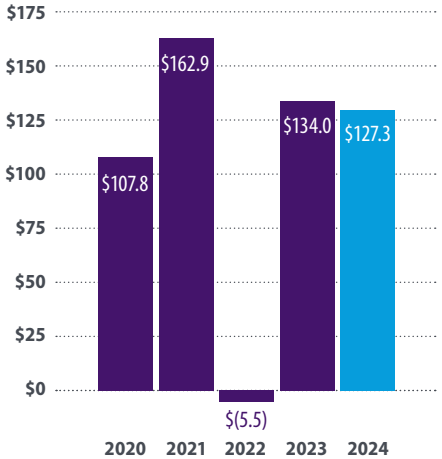
Accounting standards require organizations to recognize deferred actuarial losses and prior service credits or charges for defined benefit postretirement plans as a charge or credit to equity.

In 2024, AMA recorded a $2 million credit to equity reflecting an actuarial gain for the postretirement health care plan, net of a reclassification of actuarial gains to operating expense and income tax. The gain resulted primarily from a change in interest rates from 5 percent to 5.7 percent which reduces the present value of projected liabilities, offset by higher claims cost experience.

In 2023, AMA recorded a $17.3 million charge to equity reflecting an actuarial loss for the postretirement health care plan, net of a reclassification of actuarial gains to operating expense and income tax. The loss resulted primarily from a change in the initial health care cost trend from 7 percent to 8.5 percent and less favorable claims cost experience.

Change in total association equity

(in millions)



The AMA reported a $127.3 million increase in association equity in 2024. This reflects the amount by which revenues exceeded expenses, plus the credit to equity for changes in defined benefit postretirement plans discussed above, as well as a slight increase in donor-restricted equity.

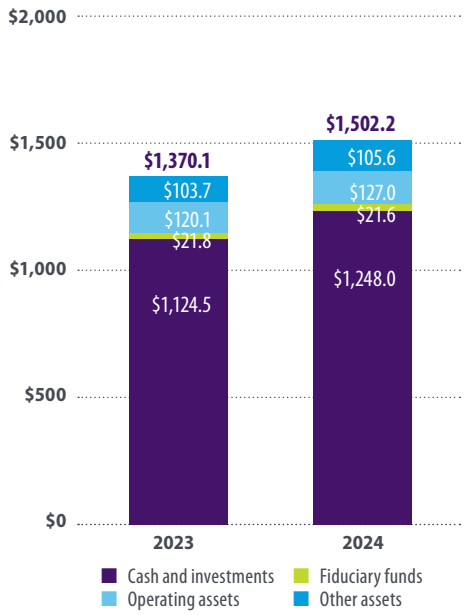
The AMA reported a $134 million increase in association equity in 2023. This reflects the amount by which revenues exceeded expenses, less the charge to equity for changes in defined benefit postretirement plans discussed above, as well as a small decrease in donor-restricted equity.

Financial position and cash flows

The AMA's assets include cash, cash equivalents and investments; operating assets such as accounts receivable, inventory and prepaid expenses; fixed capital such as equipment, information technology hardware and software; and other assets. AMA assets are supported by association equity, operating liabilities, and deferred revenue.

Assets

(in millions)



The AMA's total assets increased $132.1 million in 2024. This includes a $123.5 million increase in cash and investments resulting from $48 million in free cash flow plus a $79.7 million gain in the fair value of investment securities less $4.2 million for investments in affiliates.

Fiduciary funds are premium payments from insurance customers not yet remitted to the carriers and funds held by the AMA for third parties for future use as approved by the third parties. This approximates the offsetting liability titled insurance premiums and other fiduciary funds payable.

Operating assets increased $6.9 million in 2024, primarily due to an increase in accounts receivable. Changes in operating assets from year to year are largely due to timing of cash flows.

Other assets include operating lease right-of-use assets, property and equipment, investment in affiliates and investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Property and equipment net book value decreased as new capital spending was exceeded by annual depreciation and amortization of existing capital assets while AMA's investment in affiliates increased by $4.1 million as new investments and interest on convertible notes were reduced by AMA's share of the affiliates' operating losses.

Operating liabilities increased $9.9 million in 2024, led by increases in accrued payroll and employee benefits. A $3.7 million increase in accrued expenses was offset by a $3.7 million reduction in lease liability from cash payments exceeding rent expense.

Deferred revenue represents funds received during the year that will not be recognized as income until the following year or thereafter. These amounts vary, as well as accounts payable and accrued expenses, depending on the timing of cash receipts and payments.

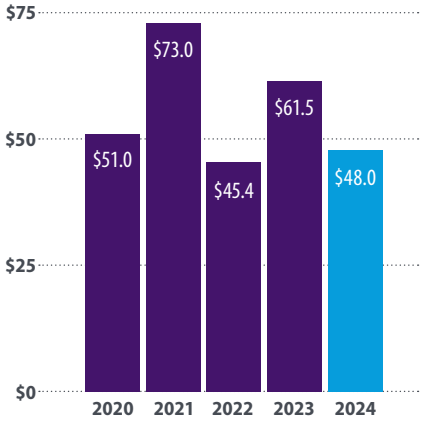
Cash flows

Cash, cash equivalents and donor-restricted cash increased $3.5 million and $2.6 million in 2024 and 2023, respectively. This comparison may cause misleading conclusions, as the change in cash and cash equivalents includes reductions for amounts invested in marketable securities, as well as cash inflows from non-operating activities.

Free cash flow measures the AMA's ability to fund operations, capital expenses and major programmatic initiatives from funds generated from operations. This measure excludes non-operating gains and losses.

Free cash

(in millions)

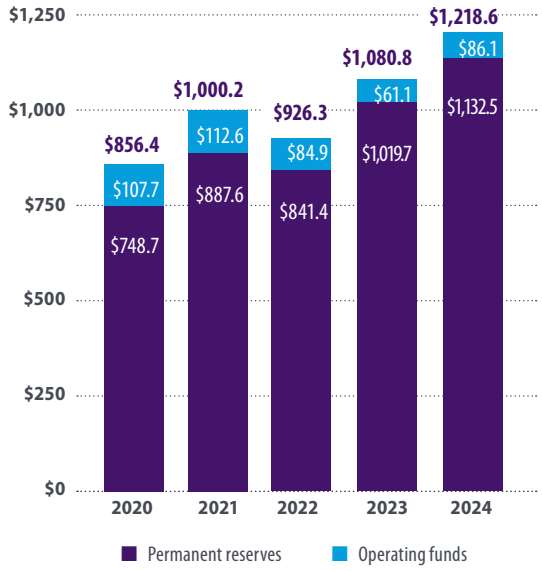


Free cash in 2024 totaled $48 million, $13.5 million less than 2023, a result of changes in operating assets and liabilities.

Reserve portfolio

Reserves and operating funds

(in millions)



The reserve and operating fund portfolios above do not include cash and investments in the for-profit subsidiaries and reflect only the not-for-profit entity's cash and investment portfolio values.

As of year-end 2024, the reserve portfolio's value was $1,132.5 million compared to $1,019.7 million in 2023, a $112.8 million increase. That increase was mainly the result of an $80.3 million gain in the fair value of the reserve portfolio plus a $30 million transfer of 2023 excess operating funds to reserves. Operating funds totaled $86.1 million in 2024, up $25 million from 2023.

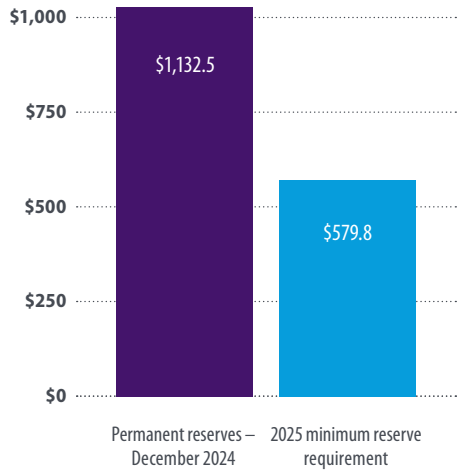
The AMA has established a required minimum reserve investment portfolio level that is adequate to cover 100 percent of annual general and administrative expenses (excluding grant expenses) plus an amount sufficient to pay long-term postretirement and lease liabilities (net of the right-of-use asset value). Operating funds, coupled with operating assets, are to be maintained at a level that allows payment of all operating liabilities.

AMA's reserves provide the backbone for the organization's long-term viability and independence, currently operating as a quasi-endowment fund, with a goal of achieving levels that could generate adequate funding to ensure the long-term future of the organization. Building these reserves to function as an endowment fund will provide considerable protection against future loss of revenue and maintain AMA's independence over the long term.

Reserve portfolio funds also provide the AMA with the ability to fund major strategic spending initiatives not within the operating budget. Spending from reserve funds is limited to dollar-or time-limited initiatives and capped at the amount by which reserves exceed the minimum requirement. Reserves may not be used for ongoing operating expenses. The Board of Trustees must authorize any use of reserves.

Permanent reserves and minimum reserve requirement

(in millions)



Group operating results

The AMA is organized into various operating groups: Membership; Publishing, Health Solutions & Insurance; Strategic Arcs, Accelerators & Core Mission Activities; Administration and Operations; Affiliated Organizations; Unallocated Overhead; and Health2047 (including subsidiary). Revenues and expenses directly attributed to those units are included in the group operating results. A financial summary of group operating results is presented at the end of this section. The prior year financial results have been updated to be consistent with the current year reported results for each group.

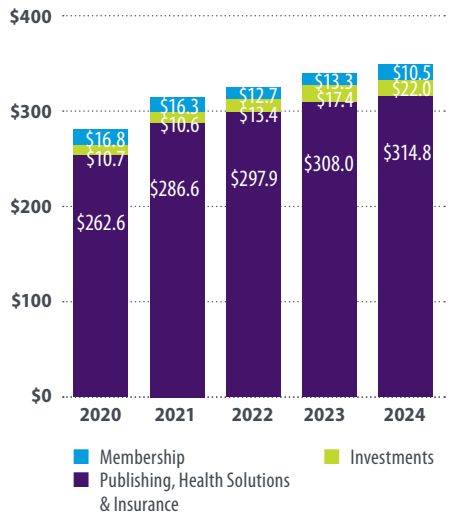
Contribution margin (net expenses)

Contribution margin equals individual group revenues minus cost of products sold, selling expenses, and direct general and administrative expenses such as compensation, occupancy, travel and meetings, technology costs and professional services.

Net expenses equals total spending, net of any revenue produced by the group, such as grants or other fee income. Total contribution margin and net expenses equals consolidated operating results before income taxes. The charts below separate groups with contribution margin from groups with net expenses.

Contribution margin

(in millions)



The contribution margin generated by Membership; Publishing, Health Solutions & Insurance; as well as Investments, provides the funding for all mission-related activities of the AMA as well as funding for all administration and support operations required to run the organization.

Membership

The Membership group's net membership dues revenue includes the gross dues revenue collected, reduced by any commissions paid to state societies, and equals the membership dues revenue reported on the statement of activities.

In 2024, AMA again reported an increase in the number of dues-paying members, up 3.1 percent from 2023. In 13 of the last 14 years, AMA has reported increases in the number of dues-paying members, a major accomplishment. Membership continues to focus on broad use of digital tools to engage physicians and retain them as lifelong members, group membership marketing, and expanding AMA's reach to physicians through programmatic mission-based activities.

Dues revenue was $32.5 million, a $0.8 million decrease from 2023. Although the number of physician members increased, most of the growth was in lower dues paying categories. In addition, revenue from lifetime memberships was fully amortized in 2023, the absence of which accounted for $0.3 million of the 2024 decrease. Membership expenses are up $2 million from staff expansion and higher membership solicitation costs. As a result, Membership's contribution margin decreased $2.8 million in 2024.

Publishing, Health Solutions & Insurance

Publications in the JAMA Network® include the *Journal of the American Medical Association (JAMA®)* and the JAMA Network specialty journals. In the last decade, the JAMA Network has launched four new journals: *JAMA Oncology* in 2015 and *JAMA Cardiology* in 2016, which are hybrid journals offering open access options for research articles; *JAMA Network Open* in 2018, a fully open access journal; and *JAMA Health Forum* in 2021, a peer-reviewed, open-access, online journal focused on health policy, health care systems, and global and public health.

Publishing revenues are derived from advertising, subscriptions, site licensing, reprints, electronic licensing, open access fees and royalties. Publishing revenues decreased $2.1 million in 2024, largely a function of a $1.9 million decline in print advertising. In late 2023, Publishing eliminated distribution of print journals to a controlled population of physicians who were included in measuring journal readership scores, a key indicator for ad placement, and expected a large drop in advertising as a result. This change reduced production and distribution costs by amounts greater than the advertising revenue loss, but inflationary price increases for printing and production offset some of the benefit. Expenses in total declined $1.1 million during 2024, as the cost of filling open positions partially offset the savings in production and distribution costs. The contribution margin declined by $1 million to break-even.

Health Solutions includes two major lines: Database Products, and Books and Digital Content.

Database Products includes royalties from licensed data sales and credentialing products revenue. Revenues increased in 2024, up $0.5 million when compared to 2023, driven by small price increases for licensed data and growth in credentialing revenues, including initial revenues from a new credentialing product, VeriCre™. This is a credentials wallet that streamlines credentialing by pre-filling physician applications with authoritative, verified AMA data, reducing administrative burden for physicians and medical staff professionals. Total expenses were up $2.4 million, of which $0.9 million relates to development of the new physician credentialing product. The remaining $1.5 million cost increase was driven by filling open positions, and market research and product development projects. The resulting contribution margin declined by $1.9 million in 2024 to $52.6 million.

AMA-published books and coding products, such as coding books and tools, workshops, and licensed data files, make up the Books and Digital Content unit. Royalties and digital content sales drove a $15.9 million revenue increase, as the market for electronic use of digital coding products continues to expand. A three percent price increase as well as phasing in previous pricing

model changes were also factors. Coding book sales declined $1.7 million in 2024 continuing the move from print products to digital. Expenses were up $2.6 million, driven by increased compensation from filling open positions and a $1.6 million increase in professional services for projects related to content and product strategy, market research and project management. The contribution margin increased by $13.3 million to $252 million.

The AMA has two active for-profit subsidiaries, the AMA Insurance Agency (Agency) and Health2047. The latter is discussed separately at the end of this discussion and analysis.

The Agency's revenue declined by $2.7 million in 2024, due to lower commissions and interest income. The Agency, as broker, receives a commission on insurance policies sold. The commission reduction was mainly due to the effect of continued decreases in commission rates to protect the viability of the plan, which allowed the Agency to avoid charging higher premiums to physician customers coupled with a reduction in coverages written. A dividend from the Agency to AMA reduced the investible funds balance, with a resulting decline in investment income. Expenses were up $0.8 million mainly due to filling open positions and merit increases. The contribution margin decreased to $13.8 million from $17.3 million in the prior year.

Other business operations net expenses were up slightly in 2024.

In total, Publishing, Health Solutions & Insurance contribution margin was $314.8 million, up $6.8 million from 2023.

Investments (AMA-only)

AMA-only investment income includes dividend and interest earnings on AMA's portfolio. Investment income in AMA's for-profit subsidiaries is included as part of the group results for Publishing, Health Solutions & Insurance and Health2047.

Investments' revenue was $22.9 million in 2024, a $4.8 million increase over the prior year. Dividend and interest income continued to improve in 2024, impacted in large part by higher interest rates as well as an increased level of investible funds. The contribution margin increased by $4.6 million as expenses were largely unchanged.

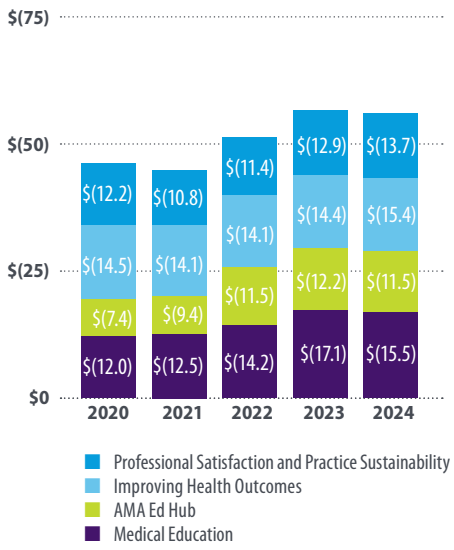
The net gain or loss on the market value of investments is not included in operating results but reported as a non-operating item. This amount is in addition to the investment income discussed above.

In 2024, AMA reported a net gain of $79.7 million. The total investment return, including investment income, on the reserve portfolios was 9.4 percent, slightly less than the 9.8 percent gain in the composite benchmark index.

Net expenses

Strategic Arcs

(in millions)



The Strategic Arcs include direct costs associated with the groups for Improving Health Outcomes (IHO), Medical Education (Med Ed), the AMA Ed Hub™ and Professional Satisfaction and Practice Sustainability (PS2).

IHO has developed empirically validated tools such as its AMA MAP™ Solutions (for hypertension control) and dashboards that, in conjunction with its well-established partnerships with the American Heart Association (AHA), Centers for Disease Control and Prevention (CDC), and the Ad Council, have positioned the initiative for national scaling and impact.

The main focus during 2024 was on hypertension outcome goals as progress continues on implementation of cloud-based MAP BP (a three-step program that works to diagnose and manage patients with hypertension) dashboards at health care organizations (HCOs), providing a visual representation of their performance on five key blood pressure metrics, including stratification by ethnicity, race and gender. IHO engaged 281 additional HCOs and reached an additional 774 thousand patients with hypertension through its solutions that helped physicians and care teams achieve blood pressure goals. In addition, the Student Blood Pressure Measurement eLearning Series received the Silver Award for excellence in design. AMA's Validated Device List, provided as a public service to help increase the use of validated blood pressure devices, had over one million viewers. In 2024, net expenses increased by $1 million, largely due to the use of outside professional services for content strategy development, point of care metrics and reporting and e-learning content.

Advancing Professional Development includes Med Ed and the AMA Ed Hub.

While the Accelerating Change in Medical Education (ACE) undergraduate medical school grants successfully concluded in 2018, AMA has continued to drive multi-school implementation of ACE innovations through ongoing support of the medical education community (ACE Consortium) via scholarly publications, and a disciplined, planned approach to spreading innovation. The five-year Reimagining Residency grants, designed to improve the transition from undergraduate to graduate medical education and to maintain and reinforce the positive changes initiated by the undergraduate consortium work, ended in 2024. Building upon the learning and momentum gained from these two programs, Med Ed will repurpose the residency grant funds to extend its efforts to apply precision education to the full continuum of professional lifelong learning and to foster diversity in the medical student and ultimately the practicing physician population. Now titled ChangeMedEd®, this initiative has inspired a community of innovation in medical education that works collaboratively to create a workforce better prepared to meet the needs of patients and communities, driving change to reduce barriers to lifelong learning, advance health equity and improve patient outcomes. One of the key outcomes of the ACE consortium was the development of Health Systems Science, a foundational platform and framework for the study and understanding of how care is delivered, how health professionals work together to deliver that care, and how the health system can improve patient care and health care delivery.

In 2024, Med Ed expanded its efforts on precision education, a system that can leverage technology and data to improve education personalization and learning efficiency across the continuum, in support of students, residents, fellows, physicians, and ultimately the needs of patients. Innovation Grants were awarded to 13 sites applying precision education approaches in medical school, residency and continuing professional development. The necessary groundwork was laid to launch the AMA Transforming Lifelong Learning Through Precision Education portfolio that will cultivate and promote democratization of the precision education ecosystem to offer individualized learning that aligns physician education with the needs of patients both now and in the future. This will include a four-year, $12 million Precision Education grant program to start in 2025. Med Ed is also responsible for defining or influencing standards for undergraduate, graduate and continuing medical education and providing support for the Council on Medical Education. Net expenses decreased $1.6 million in 2024, reflecting the end of the Reimagining Residency grant program in mid-2024.

The AMA Ed Hub, formally launched in 2018, is a multi-sided platform providing physicians and other health care providers content and educational services that support lifelong professional development. The Ed Hub has unified the AMA education portfolio and has piloted integration of external content providers, launched new content sets, and established internal development plans enterprise wide, including the Health Equity Education Center and the UME Curricular Enrichment Program. The Ed Hub also gives physicians and other health professionals a streamlined way to earn, track and report continuing medical education activities spanning clinical, practice transformation and professionalism topics. The number of external education providers on the platform grew by ten organizations to 60 organizations and the Ed Hub exceeded user engagement goals and met expectations in growth in new users. AMA's continuing medical education (CME) program achieved Accreditation with Commendation from the ACCME, the highest accreditation standard that a CME provider can receive, distinguishing the AMA as a top-tier source of trusted medical education. Net expenses were down $0.7 million in 2024 due largely to a reduced level of technology development as the Ed Hub platform has reached a stable state.

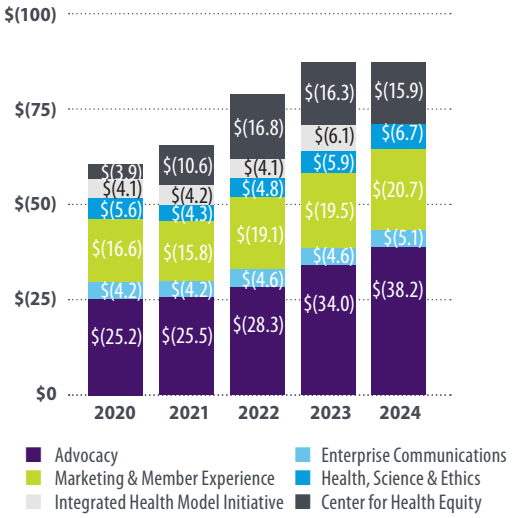
PS2 includes three major streams of work: professional satisfaction/practice transformation, practice sustainability, and digital health, all designed to improve the day-to-day practice and professional experience of physicians and remove obstacles to care. The goals of this group are to promote successful models in both the public and private sectors. This includes expanding research of credible practice science, creating tools and other solutions to help guide physicians, care teams and health system leaders on developing and implementing strategies to optimize practice efficiencies, reduce burnout and improve professional well-being; ensuring the physician perspective is represented in the design, implementation and evaluation of new health care technologies; and shaping the evolution of payment models for sustainability and satisfaction.

In 2024, the PS2 resources such as the Organizational Biopsy®, STEPS Forward®, the Joy in Medicine™ Health System Recognition Program, webinars, podcasts, coaching and learning collaboratives increased the impact of PS2 efforts with physicians as measured by the number of physicians served and the assessment of high value reflected in post-engagement surveys.

PS2 led, funded or contributed to 38 research projects on physician and practice issues, burnout, and digital health solutions and published 17 peer-reviewed studies on physician and practice issues, strengthening the evidence base for AMA solutions. The AMA Joy in Medicine Health System Recognition Program recognized 62 health systems who met the evidence-based criteria representing their commitment to organizational well-being. Providing over 90 new or updated AMA STEPS Forward resources (toolkits, webinars, podcasts, and playbooks) helped drive the user growth to over three million. AMA also co-sponsored the 2024 International Conference on Physician Health with the Canadian Medical Association and the British Medical Association with over 550 participants. In 2024, net expenses increased $0.8 million, driven almost entirely by staffing increases.

Accelerators & Core Mission Activities

(in millions)



Accelerators & Core Mission Activities currently includes five groups: Advocacy; Health, Science & Ethics; Center for Health Equity (CHE); Enterprise Communications; and Marketing & Member Experience (MMX). The Integrated Health Model Initiative, focused on technology innovation, was closed in 2023 as it became clear that the projects developed failed to achieve traction in the market.

Advocacy includes federal and state level advocacy to enact laws and advance regulations on issues important to patients and physicians; economic, statistical and market research to support advocacy efforts; political education for physicians; grassroots advocacy; and maintaining relations with the federation of medicine. This ensures that AMA's critical voice is represented in federal and state courts around the country on a broad range of issues, working with state and federal policymakers to oppose legislation and laws that interfere with the practice of medicine and elevating the voice of physician leadership on critical issues of public health.

Advocacy led the launch of a major media and grassroots campaign, "Fix Medicare Now", to urge Congress to address long-term, systemic reform of Medicare payments through the AMA's coalition. Through this campaign, policymakers are acknowledging the Medicare physician payment crisis and acting toward making permanent payment system solutions in line with AMA recommendations. In response to AMA advocacy, two important pieces of legislation were introduced that would provide crucial reforms to the Medicare physician payment system: H.R. 2474, which would enact an annual, permanent inflationary payment update in Medicare that is tied to the Medicare Economic Index and H.R. 6371, which would reform the budget neutrality policies that have been producing across-the-board payment cuts.

AMA's "Fix Prior Auth" grassroots campaign and sustained advocacy led to the Centers for Medicare & Medicaid Services releasing final regulations making important reforms to prior authorization, federal lawmakers pursuing legislative solutions, and over a dozen states enacting prior authorization reform laws supported by the AMA and state medical associations.

AMA efforts helped deliver concrete results in protecting patients from inappropriate scope of practice expansions, including the defeat of over 80 problematic bills. In 2024, Advocacy net spending increased $4.2 million, led by $2.9 million in additional media and professional service costs for the Medicare reform campaign. Use of outside professional services for other projects such as physician surveys, health legislation strategy and quality measures, accounted for most of the remaining increase.

Health, Science & Ethics is involved in developing AMA policies on scientific, public health and ethical issues for the House of Delegates; providing leadership, subject matter expertise and scientifically sound content and evidence that underpins and informs both current and future AMA initiatives in areas such as infectious disease, drug policy and opioid prescribing; overseeing maintenance of the AMA *Code of Medical Ethics* and publication of the *AMA Journal of Ethics®*, AMA's online ethics journal; and managing the United States Adopted Names (USAN) program, responsible for selecting generic names for drugs by establishing logical nomenclature classifications based on pharmacological or chemical relationships (reported separately in group operating results).

In 2024, this group provided critical expertise for updating the World Medical Association Declaration of Helsinki which sets ethical principles for biomedical research, published issues examining topical areas such as harm reduction in opioid use disorders to evidence-based architectural design in health care, supported the Firearm Injury Prevention Task Force and launched online toolkits with the CDC to help physicians and other health care professionals increase routine screenings for sexually transmitted infections and viral hepatitis. Net expenses increased $0.8 million in 2024, mainly due to staffing costs.

CHE was created in response to a Board sponsored 2018 taskforce that identified a continuing and urgent need for the AMA to play a leading and public role in eliminating health care disparities and promoting health equity through all segments of our society. In 2024, CHE devoted significant effort to working with HCOs through the Equitable Professional Societies Network under the Rise to Health Coalition of which AMA is a founding member; launched the third cohort of the Medical Justice and Advocacy Fellowship, bringing the total number of fellows to 33; held the first hybrid National Health Equity Grand Rounds; and continued engagement of Federation members, completing the second Health Equity in Organized Medicine survey. CHE continued its educational work, establishing and embedding equity education and training curriculum for AMA staff.

Additionally, CHE staff supported the Board's Truth, Reconciliation, Healing and Transformation Task Force and, with grant funding in partnership with Harvard University, initiated a multi-year archival research project that as part of its purpose will inform Task Force deliberations. CHE has largely achieved its planned level of growth and net expenses declined slightly in 2024.

MMX extends the reach and impact of AMA's mission and advocacy initiatives, builds and executes programs to grow and retain members and strengthens the AMA brand. MMX continues to take on increased oversight for managing the quality, timing and relevance of the experience physicians have at each point of interaction through AMA's digital publishing, health system engagement and member programs. MMX creates or packages AMA's content into digital formats and distributes AMA resources and thought leadership to intended audiences through owned and paid channels, raising awareness of AMA initiatives, resources and accomplishments and elevating the voice of AMA and physicians. Key results in 2024 included the launch of the "Why We Fight" campaign focused on reforming Medicare payment, fighting scope creep, fixing prior authorization, reducing physician burnout, and making technology work for physicians. MMX also focused on working collaboratively with key business units (PS2, IHO, CHE, Med Ed, Ed Hub) to expand delivery of mission value to existing and potential new health system partners and developing a pragmatic and growth-oriented marketing program for AMA's Health Equity work. AMA's audience of readers, watchers and listeners totaling 31 million in 2024.

Net expenses increased $1.2 million in 2024, with increased spending on marketing and technology to support delivery of AMA's message.

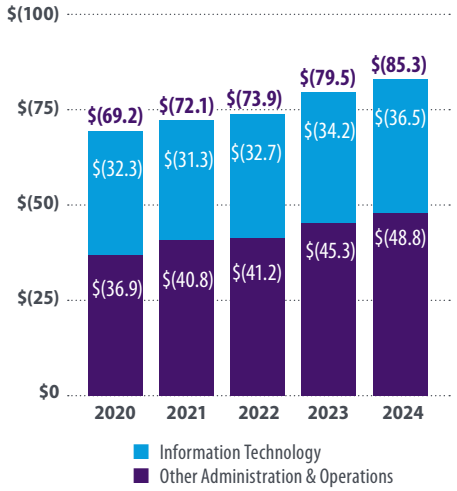
Ongoing responsibilities of the Enterprise Communications area include amplifying the work of individual operating units among their core audiences while providing consistency and alignment with the AMA narrative. Enterprise Communications distinctly communicates AMA's leading voice in science and evidence to embed equity, innovation, and advocacy across the AMA's strategic work throughout health care. Net expenses were up $0.5 million in 2024, largely due to increased staffing costs.

Governance

Governance includes the Board of Trustees and Officer Services, the House of Delegates (HOD), Sections and Special Constituencies & International units. The Board of Trustees unit includes costs related to governance activities as well as expenses associated with support of the Strategic Arcs, Accelerators and Core Mission Activities. The HOD, Sections and Special Constituencies & International unit includes costs associated with annual and interim meetings, groups, sections and other HOD activities, as well as costs associated with AMA's involvement in the World Medical Association. In 2024, Governance net spending was up $1.1 million, mainly recruiting and relocation costs.

Administration and Operations

(in millions)



These units provide administrative and operational support for Publishing & Health Solutions, Membership, Strategic Arcs, Accelerators and Core Mission Activities, as well as other operating groups. Net expenses were up 7.3 percent in 2024, an increase of $5.8 million, due to compensation costs from staff additions, filling open positions and merit increases; increased technology costs and over $1 million for use of outside resources on projects related to AMA mission-based impact and HCO research.

Affiliated Organizations

Affiliated Organizations represent either grant or in-kind service support provided by the AMA to other foundations and societies. In some cases, the AMA is reimbursed for services provided. No net expenses were reported in 2024.

Unallocated Overhead

The net expenses in this area include costs not allocated back to operating units such as corporate insurance and actuarial services, employee incentive compensation, valuation allowances or other reserves. In 2024, these expenses total $35.6 million, up $6.3 million from 2023. Higher incentive and other compensation were the main factors in the increase.

Health2047 and Subsidiary

AMA owns a business formation and commercialization enterprise designed to enhance AMA's ability to define, create, develop and launch, with partners, a portfolio of products and technologies that will have a profound impact on many aspects of the U.S. health care system and population health, with a central goal of helping physicians in practice. The AMA Board of Trustees approved the use of reserves to establish this subsidiary with plans to use third-party resources to assist in funding spinoffs with commercial potential in future years. These liquidity events generally occur somewhere between eight and twelve years after the initial spinoff.

Health2047's mission is to advance the AMA's strategic arcs by developing early-stage companies that will attract third-party investment as they mature to successful financial exits. Health2047 operates with two critical venture industry expectations: one that only a minority of early-stage start-up companies will reach maturity and consequently that it is important to aggressively manage investments and second that the industry expected timeframe for successful exit is between 8 and 12 years.

To date, twelve spinout companies have been launched, nine of which continue to operate and are attracting outside interest and investment. Given the relative youth of Health2047, none of these spinout companies have yet achieved a final financial exit. The nine spinout companies reflect a wide range of physician centric solutions including community-based diabetes prevention, Medicare Advantage for underserved populations, effective data extraction for health care enterprises, decentralized and diverse clinical trials, obesity phenotyping for precision medicine, evidence-based point of care insight, a digital learning platform for medical and health professional schools, and augmented intelligence applied to medical images.

Net expenses decreased by $3.5 million in 2024 as reductions in compensation and benefits and marketing were partially offset by increased use of consultants. In addition, the 2023 results included a $2.2 million loss on the liquidation of one of the spinout companies, which did not recur in 2024.

The summary of group operating results is included on the following page.

American Medical Association group operating results

(in millions)	Revenues 2024	Revenues 2023	Margin (Net Expenses) 2024	Margin (Net Expenses) 2023
Membership	**$ 32.5**	$ 33.3	**$ 10.5**	$ 13.3
Publishing, Health Solutions & Insurance				
Publishing	**61.7**	63.8	**-**	1.0
Books and Digital Content	**281.4**	265.5	**252.0**	238.7
Database Products	**68.2**	67.7	**52.6**	54.5
Insurance Agency/Affinity Products	**34.4**	37.1	**13.8**	17.3
Other business operations	**-**	-	**(3.6)**	(3.5)
	445.7	434.1	**314.8**	308.0
Investments (AMA-only)	**22.9**	18.1	**22.0**	17.4
Strategic Arcs, Accelerators & Core Mission Activities				
Improving Health Outcomes	**-**	-	**(15.4)**	(14.4)
Medical Education	**0.2**	0.4	**(15.5)**	(17.1)
AMA Ed Hub	**0.4**	0.3	**(11.5)**	(12.2)
Professional Satisfaction and Practice Sustainability	**-**	0.6	**(13.7)**	(12.9)
Advocacy	**0.9**	1.0	**(38.2)**	(34.0)
Health, Science & Ethics	**2.9**	2.4	**(6.7)**	(5.9)
Center for Health Equity	**0.7**	-	**(15.9)**	(16.3)
Integrated Health Model Initiative	**-**	-	**-**	(6.1)
Marketing and Member Experience	**-**	-	**(20.7)**	(19.5)
Enterprise Communications	**-**	-	**(5.1)**	(4.6)
United States Adopted Names Program	**4.7**	3.4	**3.8**	2.6
	9.8	8.1	**(138.9)**	(140.4)
Governance				
Board of Trustees and Officer Services	**-**	-	**(7.8)**	(6.8)
House of Delegates, Sections, Special Constituencies & International	**0.1**	0.1	**(11.1)**	(11.0)
	0.1	0.1	**(18.9)**	(17.8)
Administration and Operations				
Information Technology	**-**	-	**(36.5)**	(34.2)
Senior Executive Management	**-**	-	**(7.4)**	(7.5)
General Counsel	**-**	-	**(6.6)**	(6.3)
Finance & Risk Management	**-**	-	**(9.8)**	(9.0)
Human Resources	**-**	-	**(8.9)**	(8.2)
Corporate Services	**-**	-	**(6.2)**	(6.2)
Customer Service	**-**	-	**(3.7)**	(3.6)
Strategic Insights and Planning	**-**	-	**(6.2)**	(4.5)
	-	-	**(85.3)**	(79.5)
Affiliated Organizations	**0.1**	0.1	**-**	-
Unallocated Overhead	**2.1**	1.6	**(35.6)**	(29.3)
Health2047 & Subsidiary	**-**	(0.3)	**(13.4)**	(16.9)
Consolidated revenue and income before tax	**$ 513.2**	$ 495.1	**55.2**	54.8
Income taxes			**(4.1)**	(5.1)
Consolidated net operating income			**$ 51.1**	$ 49.7

Consolidated financial statements

American Medical Association and Subsidiaries

Consolidated statements of activities

Years ended December 31

(in millions)	2024	2023
Revenues		
Membership dues	$ 32.5	$ 33.3
Advertising	7.8	11.0
Journal print subscription revenues	2.2	2.7
Journal online revenues	32.2	31.6
Other publishing revenues	18.8	18.0
Books, newsletters and online product sales	22.1	23.8
Royalties and credentialing products	326.0	308.0
Insurance commissions	29.7	31.6
Investment income (Note 4)	25.7	21.3
Equity in losses of affiliates (Note 2)	(0.5)	(1.2)
Grants and other income	16.7	15.0
Total revenues	**513.2**	**495.1**
Expenses		
Cost of products sold and selling expenses	23.7	27.8
Contribution to general and administrative expenses	**489.5**	**467.3**
General and administrative expenses		
Compensation and benefits	279.4	262.0
Occupancy	19.8	21.2
Travel and meetings	20.4	19.9
Technology costs	34.4	33.9
Marketing and promotion	24.1	20.7
Professional services	35.2	29.7
Other operating expenses	21.0	25.1
Total general and administrative expenses	**434.3**	**412.5**
Operating results before income taxes	55.2	54.8
Income taxes (Note 10)	4.1	5.1
Net operating results	**51.1**	**49.7**
Non-operating items		
Net gain on investments (Note 4)	79.7	105.0
Defined benefit postretirement plan non-service periodic expense (Note 9)	(5.7)	(3.9)
Other non-operating income	0.1	0.6
Total non-operating items	**74.1**	**101.7**
Revenues in excess of expenses	**125.2**	**151.4**
Changes in defined benefit postretirement plans, other than periodic expense, net of tax (Notes 9 and 10)	2.0	(17.3)
Change in association equity	**127.2**	**134.1**
Change in donor restricted association equity		
Restricted contributions	0.7	0.6
Net assets released from restriction	(0.6)	(0.7)
Change in association equity – donor restricted	**0.1**	**(0.1)**
Change in total association equity	**127.3**	**134.0**
Total association equity at beginning of year	1,023.4	889.4
Total association equity at end of year	**$ 1,150.7**	**$ 1,023.4**

See accompanying notes to the consolidated financial statements.

American Medical Association and Subsidiaries

Consolidated statements of financial position

As of December 31

(in millions)	2024	2023
Assets		
Cash, cash equivalents and donor-restricted cash	$ 39.6	$ 36.1
Fiduciary funds (Note 2)	21.6	21.8
Investments in affiliates (Note 2)	19.4	15.3
Accounts receivable and other receivables, net of an allowance for doubtful accounts of $0.1 in 2024 and $0.3 in 2023	110.2	104.5
Inventories	1.7	2.1
Prepaid expenses and deposits	11.6	10.5
Deferred income taxes (Note 10)	3.5	3.0
Investments (Note 4)	1,208.4	1,088.4
Property and equipment, net (Note 7)	24.7	27.3
Operating lease right-of-use assets (Note 11)	50.2	51.3
Other assets (Note 6)	11.3	9.8
	$ 1,502.2	$ 1,370.1
Liabilities, deferred revenue and association equity		
Liabilities		
Accounts payable, accrued expenses and other liabilities	$ 18.8	$ 15.1
Accrued payroll and employee benefits (Note 8)	63.9	54.9
Accrued postretirement healthcare benefits (Note 9)	108.8	107.8
Insurance premiums and other fiduciary funds payable (Note 2)	21.5	21.6
Operating lease liability (Note 11)	67.4	71.1
	280.4	270.5
Deferred revenue		
Membership dues	11.5	13.2
Subscriptions, licensing, insurance commissions and royalties	56.6	59.9
Grants and other	3.0	3.1
	71.1	76.2
Association equity	1,150.6	1,023.4
Donor-restricted association equity	0.1	-
Total association equity	1,150.7	1,023.4
	$ 1,502.2	$ 1,370.1

See accompanying notes to the consolidated financial statements.

American Medical Association and Subsidiaries

Consolidated statements of cash flows

Years ended December 31

(in millions)	2024	2023
Cash flows from operating activities		
Change in total association equity	$ 127.3	$ 134.0
Adjustments to reconcile change in association equity to net cash provided by operating activities		
Depreciation and amortization	10.0	11.7
Postretirement health care expense	6.2	4.4
Noncash operating lease expense	8.9	8.9
Net gain on investments	(79.7)	(105.0)
Equity in losses of affiliates	0.5	1.2
Noncash (credit) charge for changes in defined benefit plans other than periodic expense net of tax	(2.0)	17.3
Noncash loss upon liquidation of affiliate or subsidiary	-	2.2
Loss on disposal of property and equipment	-	1.5
Bad debt expense	0.1	0.1
Other	(0.3)	(1.3)
Changes in assets and liabilities		
Accounts receivable and other receivables	(5.8)	(3.1)
Inventories	0.4	0.7
Prepaid expenses and deposits	(1.1)	1.2
Accounts payable, accrued liabilities and income taxes	(2.0)	(8.9)
Accrued postretirement benefit costs	(3.0)	(3.0)
Deferred revenue	(5.1)	5.8
Net cash provided by operating activities	54.4	67.7
Cash flows from investing activities		
Purchase of property and equipment	(6.4)	(6.2)
Investment in affiliates	(4.2)	(8.7)
Purchase of investments	(1,228.6)	(876.0)
Proceeds from sale of investments	1,188.3	825.8
Net cash used in investing activities	(50.9)	(65.1)
Net change in cash, cash equivalents and donor restricted cash	**3.5**	**2.6**
Cash, cash equivalents and donor restricted cash at beginning of year	36.1	33.5
Cash, cash equivalents and donor restricted cash at end of year	**$ 39.6**	**$ 36.1**
Noncash operating activities		
Right-of-use assets obtained in exchange for lease obligation	$ 3.1	$ 17.8
Noncash investing activities		
Accounts payable for property and equipment additions	$ 2.3	$ 1.3

See accompanying notes to the consolidated financial statements.

Notes to consolidated financial statements

For the years ended December 31, 2024 and 2023
(Columnar amounts in millions)

1. Nature of operations

The American Medical Association (AMA) is a national professional association of physicians with approximately 291 thousand members. The AMA serves the medical community and the public through standard setting and implementation in the areas of science, medical education, improving health outcomes, health equity, delivery and payment systems, ethics, representation and advocacy, policy development, and image and identity building. The AMA provides information and services to hundreds of thousands of physicians and includes journal and book publishing, physician credentialing, database licensing, insurance and other professional services for physicians.

The AMA classifies all operating results as revenues and expenses in the consolidated statements of activities. Non-operating items include net realized and unrealized gains and losses on investments, defined benefit postretirement plan non-service expense and other non-recurring income or expense.

Donor-restricted association equity includes contributions restricted for use for a scope of practice program which are not available for general use by AMA.

2. Significant accounting policies

Consolidation policy

The accompanying consolidated financial statements include the accounts of the AMA and its subsidiaries, AMA Services, Inc., American Medical Assurance Company (AMACO) and Health2047 Inc. (collectively, the AMA).

AMACO, a reinsurer for physician medical professional liability coverage, ceased accepting new and renewal business in 1986 and began running off claims under existing contracts. Since 1986, AMACO pursued the commutation of various treaties and the final treaties were commuted in 2024, with all related exposures eliminated. AMACO obtained approval from the Illinois Insurance Commissioner for a plan of dissolution and implemented that plan in 2024, with no material impact on the consolidated financial results.

AMA, through its wholly owned subsidiary, Health2047 Inc. (Health2047), has investments in nine companies or limited partnerships as of December 31, 2024.

Health2047 controls and consolidates the results of one company, First Mile Care, Inc.

The equity method of accounting is used to account for investments in companies or limited partnerships in which the AMA has significant influence but not overall control. The investments are initially recorded at the original amounts paid for common and convertible preferred stock, and subsequently adjusted for the AMA's share of undistributed earnings and losses from the underlying entities from the dates of formation. Each investment will be increased or reduced by any future additional contributions and distributions received, respectively. The cost method of accounting is used to account for investments in companies in which the AMA has neither significant influence nor overall control and where the fair value is not readily determinable.

The results of one company, Heal Security, Inc. (formed in February 2021) are accounted for under the equity method. At December 31, 2024, AMA ownership interest is 33.3% in Heal Security, Inc. The book value of the investment, net of convertible debt, at December 31, 2024 is $1 million.

In addition, at December 31, 2024, AMA has an ownership interest in seven companies or limited partnerships. The investments in these entities are accounted for using the cost method, as AMA holds less than a 20% ownership and does not exercise significant influence over the entities. This includes ownership interests of 2.9% in Zing Health Enterprises, LP (formed in May 2020), 16.4% in Medcurio Inc., (formed in February 2020), 18.7% in Phenomix Sciences, Inc. (formed in August 2020), 13.2% in Evidium, Inc. (formerly Recovery Exploration Technologies, Inc., formed in August 2021), 18.4% in Sitebridge Research, Inc. (formed in January 2021), 6% in Scholar Rx, Inc. (formed in December 2022) and 5.4% in IntellixAI, Inc. (formed in May 2023). The book value of the seven investments carried at cost at December 31, 2024 is $18.4 million.

Health2047 had investments in nine companies or limited partnerships as of December 31, 2023. Health2047 controlled and consolidated the results of one company, First Mile Care, Inc.

The companies accounted for under the equity method of accounting during 2023 were: Emergence Healthcare Group, Inc., (formed in January 2021 and liquidated in September 2023), and Heal Security, Inc.

At December 31, 2023, AMA ownership interest was 33.3% in Heal Security, Inc. The book value of the investment accounted for under the equity method, net of convertible debt, at December 31, 2023 was $0.9 million.

In addition, at December 31, 2023, AMA had ownership interest of 3.3% in Zing Health Enterprises, LP, 16.7% in Medcurio Inc., 19.1% in Phenomix Sciences, Inc., 11.3% in Evidium, Inc., 18.4% in Sitebridge Research, Inc., 6% in ScholarRx, Inc. and 6.1% in IntellixAI, Inc. The investments in these entities were accounted for using the cost method, as AMA held less than a 20% ownership and did not exercise significant influence over the entities. The book value of the seven investments carried at cost at December 31, 2023 was $14.4 million.

Use of estimates

Preparation of consolidated financial statements in conformity with accounting principles generally accepted (GAAP) in the United States of America requires management to make estimates and assumptions that affect reported amounts of assets, liabilities, revenues and expenses as reflected in the consolidated financial statements. Actual results could differ from estimates.

Cash equivalents

Cash equivalents consist of liquid investments with original maturities of three months or less and are recorded at cost, which approximates fair value.

Fiduciary funds

One of the AMA's subsidiaries, the AMA Insurance Agency, Inc., in its capacity as an insurance broker, collects premiums from the insured and, after deducting its commission, remits the premiums to the underwriter of the insurance coverage. Unremitted insurance premiums are invested on a short-term basis and are held in a fiduciary capacity. The AMA also collects and holds contributions on behalf of a separate unincorporated entity with $2.4 million held at December 31, 2024 and December 31, 2023.

Inventories

Inventories, consisting primarily of books and paper for publications, are valued at the lower of cost or net realizable value.

Property and equipment

Property and equipment are carried at cost, less accumulated depreciation and amortization. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the assets. Furniture and office equipment, hardware and software are depreciated or amortized over three to 10 years. Leasehold improvements are depreciated over the shorter of the estimated useful lives or the remaining lease term.

Revenue recognition

Revenue is recognized upon transfer of control of promised products or services to customers in an amount that reflects the consideration that AMA expects to receive in exchange for those products or services. AMA enters into contracts that generally include only one product or service and as such, are distinct and accounted for as separate performance obligations. Revenue is recognized net of allowances for returns and any taxes collected from customers, which are subsequently remitted to governmental authorities.

Membership dues are deferred and recognized as revenue in equal monthly amounts during the applicable membership year, which is a calendar year.

Licensing and subscriptions to scientific journals, site licenses, newsletters or other online products are recognized as revenue ratably over the terms of the subscriptions or service period. Advertising revenue and direct publication costs are recognized in the period the related journal is issued. Book and product sales are recognized at the time the book or product is shipped or otherwise delivered to the customer. Royalties are recognized as revenue over the royalty term. Insurance brokerage commissions on individual policies are recognized as revenue on the date they become effective or are renewed, to the extent services under the policies are complete. Brokerage commissions or plan rebates on the group products are recognized as revenue ratably over the term of the contract as services are rendered.

Contract balances

AMA records a receivable when the performance obligation is satisfied and revenue is recognized. For agreements covering subscription or service periods, AMA generally records a receivable related to revenue recognized for the subscription, license or royalty period. For sales of books and products, AMA records a receivable at the time the product is shipped or otherwise delivered to the customer. These amounts are included in accounts receivable on the consolidated statements of financial position and the balance, net of allowance for doubtful accounts, was $103.8 million and $98.4 million as of December 31, 2024 and December 31, 2023, respectively.

The allowance for doubtful accounts reflects AMA's best estimate of probable losses inherent in the accounts receivable balance. The allowance is based on historical experience and other currently available evidence.

Payment terms and conditions vary by contract type, although terms generally include a requirement of payment within 30 to 60 days. Some annual licensing agreements carry longer payment terms. In instances where the timing of revenue recognition differs from the timing of invoicing, AMA has determined that these contracts generally do not include a significant financing component.

Prepaid dues by members are included as deferred membership dues revenue in the consolidated statements of financial position. Prepayments by customers in advance of the subscription, royalty or insurance coverage period are recorded as deferred subscriptions, licensing, insurance commissions and royalty revenue in the consolidated statements of financial position.

Income taxes

The AMA is an exempt organization as defined by Section 501(c)(6) of the Internal Revenue Code and is subject to income taxes only on income determined to be unrelated business taxable income. The AMA's subsidiaries are taxable entities and are subject to income taxes. See footnote 10.

Changes in presentation

In 2024, AMA realigned its business units to reflect the current operations of the organization. As a result, the presentation of the functional expenses for 2023 in footnote 15 has been updated to be consistent with the current presentation.

3. New accounting standards update

In December 2023, Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. 2023-09, *Improvements to Income Tax Disclosures*. This requires an entity to report the amount of income taxes paid disaggregated by federal, state, and foreign taxes as well as the amount of income taxes paid disaggregated by individual jurisdictions in which income taxes paid is equal to or greater than five percent of total income taxes paid. The new standard is effective for AMA for annual periods beginning after December 15, 2025. The adoption of the standard will expand certain footnote disclosures but will not have an impact on the AMA's consolidated financial statements.

4. Investments

Investments include marketable securities and venture capital and private equity investments that are carried at fair value.

In determining fair value, the AMA uses various valuation approaches. The FASB's Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures*, establishes a hierarchy for inputs used in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the most observable inputs be used when available. Observable inputs are inputs that market participants would use in pricing the asset based on market data obtained from sources independent of the organization. Unobservable inputs are inputs that would reflect an organization's assumptions about the assumptions market participants would use in pricing the asset developed based on the best information available in the circumstances. The hierarchy is broken down into three levels based on the observability of inputs as follows:

Level 1—Valuations based on quoted prices in active markets for identical assets that the organization has the ability to access. Since valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these products does not entail a significant degree of judgment.

Level 2—Valuations based on one or more quoted prices in markets that are not active or for which all significant inputs are observable, either directly or indirectly.

Level 3—Valuations based on inputs that are unobservable and significant to the overall fair value measurement.

The availability of observable inputs can vary from instrument to instrument and is affected by a wide variety of factors, including, for example, the liquidity of markets and other characteristics particular to the transaction. To the extent that valuation is based on models or inputs that are less observable or unobservable in the market, the determination of fair value requires more judgment.

The AMA uses prices and inputs that are current as of the measurement date, obtained through a third-party custodian from independent pricing services.

A description of the valuation techniques applied to the major categories of investments measured at fair value is outlined below.

Exchange-traded equity securities are valued based on quoted prices from the exchange. To the extent these securities are actively traded, valuation adjustments are not applied and they are categorized in Level 1 of the fair value hierarchy.

Mutual funds are open-ended Securities and Exchange Commission (SEC) registered investment funds with a daily net asset value (NAV). The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy.

The fair value of corporate debt securities is estimated using recently executed transactions, market price quotations (where observable) or bond spreads. If the spread data does not reference the issuer, then data that reference a comparable issuer are used. Corporate debt securities are generally categorized in Level 2 of the fair value hierarchy.

U.S. government agency securities consist of two categories of agency issued debt. Non-callable agency issued debt securities are generally valued using dealer quotes. Callable agency issued debt securities are valued by benchmarking model-derived prices to quoted market prices and trade data for identical or comparable securities. Agency issued debt securities are categorized in Level 2 of the fair value hierarchy.

U.S. government securities are valued using quoted prices provided by a vendor or broker-dealer. These securities are categorized in Level 2 of the fair value hierarchy, as it is difficult for the custodian to accurately assess at a security level whether a quoted trade on a bond represents an active market.

Foreign and U.S. state government securities are valued using quoted prices in active markets when available. To the extent quoted prices are not available, fair value is determined based on interest rate yield curves, cross-currency basis index spreads, and country credit spreads for structures similar to the bond in terms of issuer, maturity, and seniority. These investments are generally categorized in Level 2 of the fair value hierarchy.

Investments also include investments in a diversified closed end private equity fund with a focus on buyout and secondary market opportunities in the United States and the European Union, as well as an investment in a venture capital fund focused on companies developing promising health care technologies that can be commercialized into revolutionary products and services that improve the practice of medicine and the delivery and management of health care. The investments are not redeemable and distributions are received through liquidation of the underlying assets of the funds. It is estimated that the underlying assets will be liquidated over the next four to ten years. The fair value estimates of these investments are based on NAV as provided by the investment managers. Unfunded commitments as of December 31, 2024, and December 31, 2023 totaled $76.1 million and $81.1 million, respectively.

The AMA manages its investments in accordance with Board-approved investment policies that establish investment objectives of real inflation-adjusted growth over the investment time horizon, with diversification to provide a balance between long-term growth objectives and potential liquidity needs.

The following table presents information about the AMA's investments measured at fair value as of December 31. In accordance with ASC Subtopic 820-10, investments that are measured at fair value using the NAV per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated statements of financial position.

	2024	2023
Level 1 – Quoted prices in active market for identical securities		
Equity securities	$ 588.1	$ 544.3
Fixed-income mutual funds	13.8	19.4
	601.9	563.7
Level 2 – Significant other observable inputs		
Debt securities		
Corporate	139.2	126.0
U.S. government and federal agency	275.9	254.3
Foreign government	39.4	28.3
U.S. state government	0.1	0.1
	454.6	408.7
Other investments measured at NAV – Private equity and venture capital funds	151.9	116.0
Investments	$1,208.4	$ 1,088.4

Interest and dividends are included in investment income as operating revenue while realized and unrealized gains and losses are included as a component of non-operating items.

Investment income consists of:

	2024	2023
Investment dividend and interest income	$ 30.1	$ 25.0
Management fees	(4.4)	(3.7)
	$ 25.7	$ 21.3

Investment non-operating items include:

	2024	2023
Realized gains on investments, net	$ 69.8	$ 15.2
Unrealized gains on investments, net	9.9	89.8
	$ 79.7	$ 105.0

5. Derivative instruments

In 2024, AMA began using exchange-traded U.S. Treasury note future contracts in order to efficiently manage duration of fixed income investments in the portfolio. These transactions do not qualify for hedge accounting. The fair value of the futures contracts is recognized as part of investments in the consolidated statements of financial position and changes in the fair value of these futures contracts are recognized as a component of net gain or loss on investments included in non-operating items in the consolidated statements of activities. The fair value as of December 31, 2024 and changes in fair value during 2024 were not material.

6. Other assets

Other assets include investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Mutual funds are open-ended SEC registered investment funds with a daily NAV. The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy. The investments totaled $11.3 million and $9.8 million as of December 31, 2024 and December 31, 2023, respectively.

7. Property and equipment

Property and equipment at December 31 consists of:

	2024	2023
Leasehold improvements	$ 36.1	$ 36.2
Furniture and office equipment	17.6	17.5
Information technology		
Hardware	11.4	11.6
Software	100.9	96.6
	166.0	161.9
Accumulated depreciation and amortization	(141.3)	(134.6)
Property and equipment, net	$ 24.7	$ 27.3

8. Retirement savings plan

The AMA has a 401(k) retirement and savings plan, which allows eligible employees to contribute up to 75 percent of their compensation annually, subject to Internal Revenue Service (IRS) limits. The AMA matches 100 percent of the first three percent and 50 percent of the next two percent of employee contributions. The AMA may, at its discretion, make additional contributions for any year in an amount up to two percent of the compensation for each eligible employee. Compensation is subject to IRS limits and excludes bonuses and severance pay. AMA matching and discretionary contribution expense totaled $9.8 million and $9.2 million in 2024 and 2023, respectively.

9. Postretirement health care benefits

The AMA provides health care benefits to retired employees who were employed on or prior to December 31, 2010. After that date, no individual can become a participant in the plan. Generally, qualified employees become eligible for these benefits if they retire in accordance with the plan provisions and are participating in the AMA medical plan at the time of their retirement. The AMA shares the cost of the retiree health care payments with retirees, paying approximately 60 to 80 percent of the expected benefit payments. The AMA has the right to modify or terminate the postretirement benefit plan at any time. Other employers participate in this plan and liabilities are allocated between the AMA and the other employers.

The AMA has applied for and received the federal subsidy to sponsors of retiree health care benefit plans that provides a prescription drug benefit that is actuarially equivalent to Medicare Part D under the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*. In accordance with ASC Topic 958-715, *Compensation-Retirement Benefits*, the AMA initially accounted for the subsidy as an actuarial experience gain to the accumulated postretirement benefit obligation.

The postretirement health care plan is unfunded. In accordance with ASC Topic 958-715, the AMA recognizes this liability in its consolidated statements of financial position.

The following reconciles the change in accumulated benefit obligation and the amounts included in the consolidated statements of financial position at December 31:

	2024	2023
Benefit obligation at beginning of year	$ 107.8	$ 88.1
Service cost	0.5	0.5
Interest cost	5.5	4.4
Benefits paid	(4.4)	(4.4)
Participant contributions	1.2	1.2
Federal subsidy	0.2	0.2
Actuarial (gain) loss	(2.0)	17.8
Accrued postretirement benefit costs	$ 108.8	$ 107.8

The postretirement health care plan accumulated actuarial losses not yet recognized as a component of periodic postretirement health care expense but included as an accumulated charge to equity are $6.4 million and $8.6 million at December 31, 2024 and December 31, 2023, respectively.

Actuarial assumptions used in determining the accumulated benefit obligation at December 31 are:

	2024	2023
Discount rate	5.7%	5.0%
Initial health care cost trend	8.4%	8.5%
Ultimate health care cost trend	4.0%	4.0%
Year that the rate reaches the ultimate trend rate	2048	2047

The change in the discount rate from 5.0% at the end of 2023 to 5.7% in 2024, offset by the impact of higher claims cost experience, was the major driver of the $2 million actuarial gain in 2024. The change in the initial health care cost trend from 7.0% to 8.5% and claims cost experience were the major drivers of the $17.8 million actuarial loss in 2023.

AMA recognizes postretirement health care expense in its consolidated statements of activities. The service cost component is included as part of compensation and benefits expense and the other components of expense are recognized as a non-operating item:

	2024	2023
Service cost	$ 0.5	$ 0.5
Non-service costs		
Interest cost	5.5	4.4
Amortization of actuarial loss (gain)	0.2	(0.5)
Total non-service costs	5.7	3.9
	$ 6.2	$ 4.4

Postretirement health care-related changes, other than periodic expense, that have been included as a charge or credit to unrestricted equity consist of:

	2024	2023
Actuarial gain (loss) arising during period	$ 2.0	$ (17.8)
Reclassification adjustment for recognition of actuarial loss (gain)	0.2	(0.5)
Change in association equity	$ 2.2	$ (18.3)

Actuarial assumptions used in determining postretirement health care expense are the same assumptions noted in the table above for determining the accumulated benefit obligation, except as follows:

	2024	2023
Discount rate	5.0%	5.2%
Initial health care cost trend	8.5%	7.0%

The following postretirement health care benefit payments are expected to be paid by the AMA, net of contributions by retirees and federal subsidies:

2025	$ 4.1
2026	4.6
2027	5.0
2028	5.3
2029	5.7
2030 – 2034	33.4

10. Income taxes

The provision for income taxes includes:

	2024	2023
Operating		
Current	$ 4.8	$ 4.4
Deferred	(5.2)	(4.6)
Valuation allowance	4.5	5.3
	4.1	5.1
Tax expense (benefit) related to credits or charges to equity		
Deferred	0.2	(1.0)
	$ 4.3	$ 4.1

As prescribed under ASC Topic 740, *Income Taxes*, the AMA determines its provision for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for future tax effects of temporary differences between the consolidated financial statement carrying amounts of existing assets and liabilities and their respective tax basis.

The deferred tax benefit or expense from credits or charges to equity represents the estimated tax benefit from recording unrecognized actuarial losses and prior service credits for the postretirement health care plan, pursuant to ASC Topic 958-715.

Valuation allowances are provided to reduce deferred tax assets to an amount that is more likely than not to be realized. The AMA evaluates the likelihood of realizing its deferred tax assets by estimating sources of future taxable income and assessing whether or not it is likely that future taxable income will be adequate for the AMA to realize the deferred tax asset. The valuation allowance reflects the fact that deferred tax assets include future expected benefits largely related to net operating or capital losses where recoverability will not occur until future taxable income is generated, as well as retiree health care payments that may not be deductible due to a projected lack of taxable advertising income in future years. Increases or decreases in deferred tax assets, where future benefits are considered unlikely, will result in an equal and offsetting change in the valuation reserve. If the AMA were to make a determination in future years that these deferred tax assets would be realized, the related valuation allowance would be reduced and a benefit to earnings recorded.

Deferred income taxes recognized in the consolidated statements of financial position at December 31 include the following deferred tax assets and (liabilities):

	2024	2023
Net operating and capital loss carryforward	$ 30.6	$ 26.5
Benefit plans and compensation	6.0	5.9
Right-of-use assets	(1.9)	-
Lease liabilities	2.1	-
Other	0.5	(0.1)
	37.3	32.3
Valuation allowance	(33.8)	(29.3)
	$ 3.5	$ 3.0

Cash payments for income taxes were $4.3 million and $4.4 million in 2024 and 2023, respectively, net of refunds.

AMA's federal taxes are open to examination by taxing authorities from 2021 through 2024. AMA's state taxes are open to examination for various years depending on the jurisdiction.

11. Leases

AMA leases office space at a number of locations and the initial terms of the office leases range from four years to 15 years. Most office space leases have options to renew at then prevailing market rates, or, in one circumstance, early terminate or contract with appropriate notice and termination payments. As any renewal, termination, or contraction is at the sole discretion of AMA, and at this date is not certain, renewal and termination options are not included in the right-of-use asset (ROU asset) or lease liability. AMA also leases copiers and printers in several locations, with initial terms generally of four years.

The lease agreements do not contain variable lease payments, residual value guarantees or material restrictive covenants. All leases are classified as operating leases.

AMA leases do not provide an implicit interest rate and as such, AMA calculates the lease liability at lease commencement or remeasurement date as the present value of unpaid lease payments using an estimated incremental borrowing rate. The incremental borrowing rate represents the rate of interest that AMA estimates it would have to pay to borrow an amount equal to the lease payments on a collateralized basis over a similar term, based on information available at the time of commencement or remeasurement.

During 2024, AMA entered into a new office space lease which resulted in a $3.1 million increase in the ROU asset and corresponding lease liability.

During 2023, AMA extended the term of the main headquarters lease for an additional seven years in return for certain concessions. The ROU asset and lease liability were remeasured as of the modification date and the impact of the extension is a $17.7 million increase in the ROU asset and corresponding lease liability. In addition, AMA exercised early termination options of two small satellite office leases, with a termination penalty. The impact of the early terminations was not material.

Operating lease costs totaled $8.9 million in both 2024 and 2023. Cash paid for amounts included in the measurement of lease liabilities totaled $11.5 million in 2024 and $15.3 million in 2023.

The remaining weighted-average lease term is 9.9 years and 11.1 years as of December 31, 2024 and December 31, 2023, respectively. The weighted-average discount rate used for operating leases is 6.9% and 7.2% for 2024 and 2023, respectively.

The maturity of lease liabilities as of December 31, 2024:

2025	$ 8.9
2026	2.6
2027	2.6
2028	6.4
2029	13.1
2030 and beyond	68.0
Total lease payments	101.6
Less imputed interest	(34.2)
Present value of lease obligations	$ 67.4

12. Financial asset availability and liquidity

AMA has a formal reserve policy that defines the reserve investment portfolios as pools of liquid net assets that can be accessed to mitigate the impact of undesirable financial events or to pursue opportunities of strategic importance that may arise, as well as provide a source of capital appreciation. The policy establishes minimum required dollar levels required to be held in the portfolios (defined as an amount equal to one-year's general and administrative operating expenses plus long-term liabilities). The policy also covers the use of dividend and interest income, establishes criteria for use of the funds and outlines the handling of excess operating funds on an annual basis.

Dividend and interest income generated from the reserve portfolios are transferred to operating funds monthly and used to fund operations. The formal reserve policy contemplates use of reserve portfolio funds for board approved time- or dollar-limited strategic outlays, to the extent that the reserve portfolio balances exceed the minimum amount established by policy.

All surplus funds generated from operations annually (defined as operating cash plus other current assets minus current liabilities and deferred revenue at year end) are transferred to the reserve portfolios after year-end. The reserve policy does not cover the for-profit subsidiaries' activities.

AMA invests cash in excess of projected weekly requirements in short-term investments and money market funds. AMA does not maintain any credit facilities as the reserve portfolios provide ample protection against any liquidity needs.

The following reflects AMA's financial assets as of December 31 reduced by amounts not available for general use that have been set aside for long-term investing in the reserve investment portfolios or funds subject to donor restrictions. AMA's financial assets include cash, cash equivalents and donor restricted cash, short-term investments and long-term investments in the reserve portfolios.

	2024	2023
Financial assets	$1,248.0	$1,124.5
Less assets unavailable for general expenditures:		
Restricted by donor with purpose restrictions	(0.1)	-
Restricted by governing body primarily for long-term investing or for governing body approved outlays	(1,132.5)	(1,021.2)
Financial assets available to meet cash needs for general expenditures within one year	$ 115.4	$ 103.3

In addition to financial assets available to meet general expenditures over the next 12 months, the AMA operates under a policy that requires an annual budget surplus, excluding time- or dollar-limited strategic expenditures approved by the board, and anticipates generating sufficient revenue to cover general ongoing expenditures on an annual basis.

13. Contingencies

In the opinion of management, there are no pending legal actions for which the ultimate liability will have a material effect on the equity of the AMA.

14. Subsequent events

ASC Topic 855, *Subsequent Events*, establishes general standards of accounting for and disclosure of events that occur after the consolidated balance sheet date but before consolidated financial statements are issued or are available to be issued.

For the year ended December 31, 2024, the AMA has evaluated all subsequent events through February 14, 2025, which is the date the consolidated financial statements were available to be issued, and concluded no additional subsequent events have occurred that would require recognition or disclosure in these consolidated financial statements that have not already been accounted for.

15. Functional expenses

The costs of providing program and other activities have been summarized on a functional basis in the consolidated statements of activities. Certain costs have been allocated among the Membership; Publishing, Health Solutions and Insurance; Strategic Arcs and Core Mission Activities and other supporting services.

The expenses that are allocated and the method of allocation include the following: fringe benefits based on percentage of compensation and occupancy based on square footage. All other expenses are direct expenses of each functional area.

	Membership	Publishing, Health Solutions and Insurance	Investments (AMA only)	Strategic Arcs and Core Mission Activities	Governance, Administration and Operations	Health2047 and Subsidiaries	Total
Cost of products sold and selling expense	$ -	$ 23.7	$ -	$ -	$ -	$ -	$ 23.7
Compensation and benefits	7.4	72.6	-	86.3	105.4	7.7	279.4
Occupancy	0.6	5.5	-	6.8	6.1	0.8	19.8
Travel and meetings	0.1	3.9	-	7.5	8.5	0.4	20.4
Technology costs	1.1	12.5	-	7.4	13.2	0.2	34.4
Marketing and promotion	11.5	0.9	-	11.5	-	0.2	24.1
Professional services	0.4	6.5	0.2	19.4	5.1	3.6	35.2
Other operating expense	0.9	5.3	0.7	9.8	3.8	0.5	21.0
2024 total expense	**$ 22.0**	**$ 130.9**	**$ 0.9**	**$ 148.7**	**$ 142.1**	**$ 13.4**	**$ 458.0**
Cost of products sold and selling expense	$ -	$ 27.8	$ -	$ -	$ -	$ -	$ 27.8
Compensation and benefits	6.7	66.5	-	86.6	93.7	8.5	262.0
Occupancy	0.5	5.5	-	7.0	7.3	0.9	21.2
Travel and meetings	0.1	3.4	-	7.9	8.0	0.5	19.9
Technology costs	1.1	12.2	-	8.3	12.2	0.1	33.9
Marketing and promotion	10.5	1.2	-	8.3	-	0.7	20.7
Professional services	0.2	4.4	0.3	18.3	3.4	3.1	29.7
Other operating expense	0.9	5.1	0.4	12.1	3.8	2.8	25.1
2023 total expense	**$ 20.0**	**$ 126.1**	**$ 0.7**	**$ 148.5**	**$ 128.4**	**$ 16.6**	**$ 440.3**

Independent auditor's report

The Board of Trustees of American Medical Association

Opinion

We have audited the consolidated financial statements of American Medical Association (the "AMA") and subsidiaries, which comprise the consolidated statements of financial position as of December 31, 2024 and 2023, and the related consolidated statements of activities and cash flows for the years then ended, and the related notes to the consolidated financial statements (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the AMA as of December 31, 2024 and 2023, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the AMA and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the AMA's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Deloitte & Touche LLP
Chicago, Illinois
February 14, 2025

Written statement of certification of Chief Executive Officer and Chief Financial Officer

The undersigned hereby certify that the information contained in the consolidated financial statements of the American Medical Association for the years ended December 31, 2024 and 2023 fairly present, in all material respects, the financial condition and the results of operations of the American Medical Association.

James L. Madara, MD
Executive Vice President and Chief Executive Officer

Denise M. Hagerty
Senior Vice President and Chief Financial Officer

February 14, 2025

Officers and trustees

Standing committees

Executive Committee

Dr. Suk, chair
Dr. Aizuss
Dr. Scott
Dr. Mukkamala
Dr. Ehrenfeld
Dr. Ajayi
Dr. Egbert
Dr. Underwood

Audit Committee

Dr. Ding, chair
Ms. Breig
Dr. Butler
Dr. Egbert
Dr. Ehrenfeld
Dr. Ferguson
Dr. Underwood
Dr. Aizuss
Dr. Scott
Dr. Suk

Awards and Nominations

Dr. Heine, chair
Dr. Ajayi
Dr. Armstrong
Dr. Garretson
Dr. Jeffers
Ms. Siddiqui
Dr. Welsh
Dr. Scott
Dr. Aizuss
Dr. Suk
Dr. Underwood

Compensation Committee

Dr. Mukkamala, chair
Dr. Aizuss
Dr. Ajayi
Dr. Levin
Dr. Butler
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Governance and Self-Assessment Committee

Dr. Ehrenfeld, chair
Dr. Ding
Dr. Butler
Dr. Heine
Dr. Mukkamala
Dr. Suk
Dr. Aizuss
Dr. Underwood
Dr. Scott

Finance Committee

Dr. Butler, chair
Dr. Ding
Dr. Fryhofer
Dr. Ferguson
Dr. Koirala
Dr. Levin
Dr. Mukkamala
Dr. Scott
Dr. Suk
Dr. Underwood
Dr. Aizuss

Note: Drs. Suk, Aizuss and Underwood serve on all committees, except where otherwise noted, as ex-officio members without vote.
Dr. Scott serves on all committees as an ex-officio member with vote.

AMA
AMERICAN MEDICAL ASSOCIATION

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 04-A-25

Subject: AMA 2026 Dues

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee F

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.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 22-A-25

Subject: Ranked Choice Voting

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee F

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:

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- 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.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 23-A-25

Subject: Financial Assistance to Facilitate Attendance at MSS Meetings

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee F

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."[1] 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 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

[1] See Appendix for full text of AMA Policy G-665.998.

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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 explore alternate mechanisms to provide financial assistance to facilitate attendance at MSS meetings with a report back at the ~~2025~~ 2026 Annual Meeting. (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.

REPORT OF THE BOARD OF TRUSTEES (A-25)
Creation of an AMA Council with a Focus on Digital Health Technologies and AI
Reference Committee F

EXECUTIVE SUMMARY

At the 2024 Annual Meeting of the House of Delegates, Policy G-615.998, "Creation of an AMA Council with a Focus on Digital Health Technologies and AI," was adopted, which directed the American Medical Association (AMA) to establish a task force by the 2024 Interim Meeting focused on digital health, technology, informatics, and augmented/artificial intelligence with the potential to transition of this task force to a new council and report back at the 2025 Annual Meeting on this transition.

In September 2024, a task force charter was proposed to and approved by the AMA Board of Trustees. 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 resource and policy gaps, and amplify physicians' voices in health care technology advancements. It was determined that a decision would be made on the long-term model for HOD input after two years.

The task force was launched at the 2024 Interim meeting and comprised 22 individuals including members from the Board, AMA councils, delegate and alternate delegates, AMA group members, and members from the public.

The task force held its inaugural meeting in February 2025 to introduce members, establish goals, and outline key needs for developing recommendations. Members received an overview of the AMA's structure and its ongoing work in digital health, AI, and informatics. Discussions centered on defining success, setting priorities, and identifying necessary resources for informed recommendations by the end of the two-year charter period. The task force is reflecting on these initial discussions to refine its focus and informational needs, with the next meeting set for June 2025 and additional virtual sessions to occur as needed.

This report also provides relevant AMA resources and policy. Resources include research, educational content, specialty collaboratives, networking communities comprising physicians and leadership across the health care technology industry, and events. AMA policy areas include electronic health records (meaningful use, interoperability, and documentation), AI (misinformation, medical education, and prior authorization), data privacy, payment for electronic communications, the use of mobile health technology in practices, and telehealth (ethics, licensure, equity, coding, and reimbursement).

The Board of Trustees recommends that Policy G-615.998, "Creation of an AMA Council with a Focus on Digital Health Technologies and AI," be rescinded as having been fulfilled by this report.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 24-A-25

Subject: Creation of an AMA Council with a Focus on Digital Health Technologies and AI

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee F

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.

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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 Policy G-615.998, "Creation of an AMA Council with a Focus on Digital Health Technologies and AI," be rescinded as having been fulfilled by this report and that the remainder of this report be filed.

Fiscal Note: $330,000

JOINT REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS AND THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CCB/CLRPD Report 1-A-25

Subject: Joint Council Sunset Review of 2015 House Policies

Presented by: Jerry P. Abraham, MD, MPH, Chair, Council on Constitution and Bylaws
Michelle A. Berger, MD, Chair, Council on Long Range Planning and Development

Referred to: Reference Committee F

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-600.110 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates (House) adopts policies, a maximum 10-year time horizon shall exist. A policy will typically sunset after 10 years unless action is taken by the House to retain it. Any action of our AMA House 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 House 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 (per Policy G-600.111(4), The consolidation process permits editorial amendments for the sake of clarity, so long as the proposed changes are transparent to the House and do not change the meaning); (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates 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 House of Delegates 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 House of Delegates Reference Manual: Procedures, Policies and Practices.

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

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

RECOMMENDATION

The Councils on Constitution and Bylaws and Long Range Planning and Development recommend that the House policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-350.984	Reducing Discrimination in the Practice of Medicine and Health Care Education	Our American Medical Association will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.	1. Retain D-350.984 as editorially amended for accuracy; 2. Consolidate D-350.984 with H-65.952 as follows: H-69.952, Racism as a Public Health Threat. 1. Our American Medical Association acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole. 2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care. 3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: The causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; How to prevent and ameliorate the health effects of racism. 4. Our AMA: supports the development of policy to combat racism and its effects; encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them. 5. ~~D-350.984~~ Our American Medical Association ~~will pursue avenues to~~

Policy Number	Title	Text	Recommendation
			supports collaborating ~~collaborate~~ with public health organizations ~~the American Public Health Association's National Campaign Against Racism~~ on their campaigns against racism ~~in those areas~~ where aligned with AMA's current activities ~~align with the campaign~~. 6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies. *Note:* The APHA's Campaign Against Racism, conceived by APHA past president Dr. Camara Jones, transitioned from APHA to EqualHealth.
D-445.998	Confusion Regarding Use of the Term "Doctor"	Our AMA will strongly encourage the media to require that the actual degree be affixed to the name of all who endorse health-related products.	Retain D-445.998. Still Relevant.
D-630.968	Donating Reimbursements to the American Medical Association Foundation	Our AMA will add verbiage to its non-staff expense form directing individuals to the AMA Foundation's website should they wish to make a contribution.	Sunset D-630.968. The action requested was accomplished. Beginning in 2015, expense reimbursement forms have included the following language, "Please consider a donation to the AMA Foundation [website and phone # provided.]"
G-615.035	Technology and the Practice of Medicine	Our AMA encourages the collaboration of existing AMA Councils and working groups on matters of new and developing technology, particularly electronic medical records (EMR) and telemedicine.	Sunset G-615.035. Superseded by more recent policies including G-615.998, Creation of an AMA Council with a Focus on Digital Health Technologies and AI. [The task force includes leadership from all AMA Councils.]
G-640.005	AMA Advocacy Analysis	Our AMA Board of Trustees will provide a report to the House of Delegates at each Interim Meeting highlighting the prior year advocacy activities to include efforts, successes, challenges, and recommendations / actions to further optimize advocacy efforts.	Retain. Still Relevant.

Policy Number	Title	Text	Recommendation
H-140.840	Filming Patients for News or Entertainment	American Medical Association policy is that efforts to disguise a patient (such as blurring the face, changing the voice, or any other technique) do not substitute for the need to obtain consent, as outlined in AMA Ethical Opinion E-5.045, for publication of any material related to the treatment of a patient.	Retain H-140.840 as editorially amended for accuracy as follows: H.140.840, Filming Patients for News or Entertainment. American Medical Association policy is that efforts to disguise a patient (such as blurring the face, changing the voice, or any other technique) do not substitute for the need to obtain consent, as outlined in the AMA Code of Medical Ethics Ethical Opinion-E-3.1.4, Audio or Visual Recording of Patients for Public Education ~~E-5.045, for publication of any material related to the treatment of a patient~~. *Note:* When the AMA Code of Medical Ethics was modernized in 2016, Opinion #s changed.
H-140.997	Patient Advocacy	Our AMA believes that physicians are the primary patient advocates, are not rationers of medical care, and will continue to utilize diagnostic and therapeutic measures and facilities in the best interest of the individual patient.	Retain H-140.997. Still Relevant.
H-175.972	Plea Bargaining and Immunity from Prosecution	Our AMA opposes the use of harassment and coercive plea bargaining by prosecutors to pressure physicians.	Retain Policy H-175.972. Still Relevant.
H-265.990	Expert Witness Affirmation	AMA policy is that all physicians, serving as expert witnesses in medical liability litigation, voluntarily sign an expert witness affirmation explicitly stating that they will adhere to the AMA's principles guiding expert witness testimony.	Sunset. This policy dates back to 2004; AMA legal counsel notes that once such an affirmation is signed, it is likely discoverable and would be an opening for opposing counsel to question the credibility of the witness. Conceivably, it might also disqualify the witness. *Note*: AMA has more recent policy related to expert witnesses, including H-265.992, Expert Witness Testimony, H-265.994, Expert Witness Testimony, and H-265.995, Guidelines for Expert Witness. The AMA Code of Medical Ethics also addresses expert witness testimony.
H-40.966	Military Medical Policies Affecting Transgender Individuals	Our American Medical Association affirms that there is no medically valid reason to exclude transgender individuals from service in the US military and	Retain Policy H-40.960. Still Relevant.

Policy Number	Title	Text	Recommendation
		affirms transgender service members be provided care as determined by patient and physician according to the same medical standards that apply to non-transgender personnel.	
H-480.988	Allocation of Privileges to Use Health Care Technologies	The AMA (1) affirms the need for the Association and specialty societies to enhance their leadership role in providing guidance on the training, experience and knowledge necessary for the application of specific health care technologies; (2) urges physicians to continue to ensure that, for every patient, technologies will be utilized in the safest and most effective manner by health care professionals; and (3) asserts that licensure of physicians by states must be based on scientific and clinical criteria.	Retain Policy H-480.988. Still Relevant.
H-520.995	Nuclear Weapons Reduction	The AMA supports continued efforts to publicize its position that there is no adequate medical response to nuclear war.	1. Retain Policy H-520.995; 2. Consolidate with Policy H-520.999 into a single comprehensive policy as follows: H-520.999, Opposition to Nuclear War. (1). The AMA recognizes the catastrophic dangers to all life in the event of nuclear war and supports efforts for the prevention of such a nuclear holocaust. ~~H-520.995, Opposition to Nuclear War Nuclear Weapons Reduction.~~ (2) The AMA supports continued efforts to publicize its position that there is no adequate medical response to nuclear war.
H-520.996	Arms Reduction	The AMA encourages the President and Congress to continue the process of bilateral and verifiable nuclear arms reduction.	1. Retain Policy H-520.996; 2. Consolidate with H-520.994 and H-520.988 into a single comprehensive policy as follows: H-520.996, Arms Reduction. (1) ~~H-520.994, Nuclear Test Ban.~~ The AMA acknowledges the threat from nuclear weapons to the health of the people of the world and favors the establishment of a mutual, verifiable, and comprehensive nuclear test ban. (2) ~~H-520.988, Abolition of Nuclear Weapons and Other Weapons of Mass and Indiscriminate Destruction.~~ The AMA supports the elimination by all nations of nuclear weapons and other weapons

Policy Number	Title	Text	Recommendation
			of mass and indiscriminate destruction. (3) The AMA encourages the President and Congress to continue the process of bilateral and verifiable nuclear arms reduction.
H-65.966	Physicians Response to Victims of Human Trafficking	1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking. Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims. The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children. The Polaris Project - In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project: - Operates a 24-hour National Human Trafficking Hotline - Maintains the National Human Trafficking Resource Center, which provides a. An assessment tool for health care professionals b. Online training in recognizing and responding to human trafficking in a health care context	1. Retain H-65.966. 2. Sunset D-170.992, Human Trafficking / Slavery Awareness (as it is superseded by more current policy; 3. Consolidate H-65.966 and H-440.814 into a single comprehensive Policy as follows: H-65.966,Physicians Response to Victims of Human Trafficking. 1. Our AMA encourages its ~~Member Groups and Sections~~ members, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking. Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims. ~~The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.~~ ~~The Polaris Project -~~ ~~In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:~~ ~~- Operates a 24-hour National Human Trafficking Hotline~~

Policy Number	Title	Text	Recommendation
		c. Speakers and materials for in-person training d. Links to local resources across the country The Rescue & Restore Campaign - The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals. 2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.	~~- Maintains the National Human Trafficking Resource Center, which provides~~ ~~a. An assessment tool for health care professionals~~ ~~b. Online training in recognizing and responding to human trafficking in a health care context~~ ~~c. Speakers and materials for in-person training~~ ~~d. Links to local resources across the country~~ ~~The Rescue & Restore Campaign - The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.~~ 2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs. 3. ~~H-440.814, Distribution and Display of Human Trafficking Aid Information in Public Places~~ ~~1.~~ Our AMA policy is that readily visible signs, notices, posters, placards, and other readily available educational materials providing information about reporting human trafficking activities or providing assistance to victims and survivors be permitted in local clinics, emergency departments, or other medical settings. 4. ~~2.~~ Our AMA, through its website or internet presence, will provide downloadable materials displaying the National Human Trafficking Hotline number to aid in displaying such information in local clinics, emergency departments, or other medical settings and advocate that other recognized medical professional organizations do the same.

Policy Number	Title	Text	Recommendation
			5. ~~3.~~ Our AMA urges the federal government to make changes in laws to advocate for the broad posting of the National Human Trafficking Hotline number in areas such as local clinics, emergency departments, and other medical settings. *N*ote: US Department of State website includes definitions/details about what specific bureaus are doing to support this policy issue. The definition of human trafficking continues to evolve. The AMA *Code of Medical Ethics* offers physicians guidance on their obligation to take appropriate action. AMA's website provides additional resources.
H-65.997	Human Rights	Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.	Sunset. Duplicative of Policy H.65.991 (see below).
H-65.981	Human Rights and Health Professionals	The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims.	1. Retain. 2. Consolidate with H-65.991 into a single comprehensive policy (see below)
H-65.991	Persecution of Physicians for Political Reasons and Participation by Doctors in Violations of Human Rights	The AMA (1) reiterates its endorsement of the 1975 World Medical Association Declaration of Tokyo which provides guidelines for physicians in cases of torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment; (2) opposes participation by physicians in the torture or inhuman treatment or punishment of individuals in relation to detention and imprisonment; and (3) expresses its sympathy to those physicians who have been subject to imprisonment or torture because of their	1. Retain. 2. Consolidate with H-65.981 as editorially amended as follows: H-65.981, Human Rights and Health Professionals. 1. The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims. 2. ~~H-65.991~~ The AMA ~~(1)~~ reiterates its endorsement of the ~~1975~~ World Medical Association Declaration of Tokyo: Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or

Policy Number	Title	Text	Recommendation
		humanitarian efforts to improve the health of their patients.	Punishment in Relation to Detention and Imprisonment, which ~~provides guidelines for physicians in cases of torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment;~~ ~~(2)~~ opposes participation by physicians in ~~the~~ torture or other forms of cruel, inhuman or degrading procedures on detainees or prisoners. ~~inhuman treatment or punishment of individuals in relation to detention and imprisonment; and~~ ~~(3)~~ The AMA expresses its sympathy to those physicians who have been subject to imprisonment or torture because of their humanitarian efforts to improve the health of their patients. *Note:* Link to WMA Declaration of Tokyo: Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment (which has been amended several times since 1975). The AMA Code of Medical Ethics also addresses this issue.

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-A-25

Subject: International Medical Graduates Section Five-Year Review

Presented by: Michelle Berger, MD, Chair

Referred to: Reference Committee F

The Council on Long Range Planning and Development (CLRPD) analyzed information from a letter of application submitted in June 2024 from the International Medical Graduates Section (IMGS) for renewal of delineated section status and representation in the American Medical Association (AMA) House of Delegates (HOD). The letter focuses on activities beginning in June 2019.

AMA Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every five years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

APPLICATION OF CRITERIA

Criterion 1: Issue of Concern – Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

Since its transition from the IMG Advisory Committee to a Section in 1997, The IMGS has worked to fulfill the objectives of its mission statement:

1. Increase the impact of IMG viewpoints in organized medicine
2. Promote IMG participation and visibility at all levels of organized medicine
3. Establish two-way communication between grassroots IMGs and organized medicine
4. Represent the views of IMGs in the AMA HOD

The IMGS is the only group within the AMA that represents and promotes the interests of physicians who have graduated from medical schools outside the United States or Canada. The IMGS serves its constituents by bringing critical IMG professional issues to the forefront of organized medicine and by providing targeted educational and policy resources.

Over the past five years, the Section has focused on core issues affecting IMGs in the United States including licensure parity, immigration, graduate medical education expansion and discrimination. The IMGS collaborates with the AMA Advocacy unit to work toward uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating

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disparity in the years of GME required for licensure and a uniform standard for the allowed number of administrations of licensure examinations. The IMGS works with the AMA Washington D.C. office to stay abreast of the immigration issues that affect the J-1 Visa Waiver and Conrad 30 Waiver programs for IMGs practicing in underserved areas. IMGS members contributed to the AMA's testimony before the National Academy of Medicine Graduate Medical Education (GME) Financing Committee on the issue of GME expansion. Discriminatory issues have been addressed by the IMGS through policy initiatives, educational sessions, open forums, immigration webinars, employment contract guidelines, amicus briefs, and advocacy for equity in leadership positions. Some professional issues addressed include the Bachelor of Medicine, Bachelor of Surgery (MBBS) degree equivalent, licensure disparity, disparities in the residency selection process, and visa issues related to delays, denials, caps and green card backlogs. The IMGS has worked with AMA Washington D.C. office staff to communicate to the United States Citizenship Immigration Services, U.S. Senators and Representatives regarding these issues. Additionally, the Section has identified and worked to affect the following issues of concern for IMGs:

Providing ongoing support on issues affecting IMGs

The IMGS receives many inquiries regarding immigration, J-1 visa issues, licensure, residency positions, observerships, and mentoring. In response to these requests, in addition to providing direct support, the Section developed an IMG Toolkit, which is posted on the AMA website and is updated regularly. Staff of the Section keep track of all inquiries and work with the Governing Council (GC) on how to best provide the appropriate resources to assist IMGs.

Mentorship

The Section regularly receives communications from its members requesting mentors or a mentorship program. IMG students and early residents are often unfamiliar with the requirements and challenges of practicing medicine in the United States. In response, the IMGS has developed a listing of over 65 volunteer mentors to assist in this regard. IMG staff have also worked with the Governance and Policy Group Committee to determine how to develop an AMA mentorship program.

IMG representation in leadership positions

IMGs have historically been underrepresented in leadership positions in organized medicine, and the IMGS consistently encourages its core members to apply for leadership positions. The Section has also included a Section on Board/Council Endorsements in its Internal Operating Procedures (IOP), which was approved in 2022, as an offering to those IMGs who are interested in applying for an endorsement.

Inclusion of IMGs in the AMA's Equity Strategic Plan

The IMGS collaborated with the Center for Health Equity (CHE) to integrate IMG issues into the AMA's Organizational Strategic Plan to Advance Health Equity. This led to a pull-out section on IMGs in the Strategic Plan and participation in the A-24 Health Equity forum panel discussion. The IMGS GC and staff work with CHE on a regular basis to provide IMG insights for the Center's work.

Many IMGs in the United States are still unaware that the AMA has an IMGS and subject matter experts to assist them. Once they became aware of this information, many IMG physicians and residents have joined the AMA as demonstrated by the increased membership numbers in the past

five years. There are also U.S. citizens attending Caribbean medical schools that have an interest in joining the AMA; however, current AMA policy and bylaws prohibit this until they have become ECFMG-certified, an issue the IMGS hopes to address.

Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

The IMGS works with its GC to align its work with the AMA's and the Section's Strategic Plan and to inform members and non-members how the AMA has worked to remove obstacles that interfere with patient care, confront chronic disease and eliminate health disparities, and drive the future of medicine by reimagining medical education. The IMGS has collaborated with the Council on Medical Education, CHE, Advocacy and other units, sections and special groups on its priority issues to maximize impact and avoid duplicative effort. Since its inception, the IMGS has submitted more than 125 resolutions to the HOD, including 19 since 2019, on topics relevant to IMGs, while also contributing and providing input to HOD reports when appropriate. The IMGS also reviews and revises its strategic plan on an annual basis to ensure relevance and alignment with AMA priorities.

Criterion 3: Appropriateness – The structure of the group will be consistent with its objectives and activities.

Each year the Section works with its GC to develop its Strategic Plan to focus on priority initiatives. GC and committee meetings are held on a regular basis. In 2024, the Section began "Conversation Circles" on topics of interest suggested by its IMGS membership. To date, the Section has held two sessions attended by over 30 participants. The GC meets four to six times a year. Committees meet quarterly and as needed to address issues of immediate concern. Email inquiries received via the IMG mailbox deemed important to address are shared with the GC. Issues addressed and success stories are shared via the IMGS communication vehicles, including newsletters, email, Facebook and LinkedIn.

The IMGS provides direct opportunities for its members to participate in the policymaking process twice a year. These opportunities are announced in advance of annual and interim meetings to allow members time for comment and ratification of reports and resolutions via the Section's online member forum. The Section makes the resolution guidelines and checklist available to members via its newsletters, website and Facebook group. All resolutions are vetted by the Section's Delegates, the Resolution and Policy Committee, followed by the GC and Congress Assembly.

The IMGS GC election is held annually, with calls for nominations announced in December and accepted through February 22. Nominations are reviewed and scored by the IMGS Nominating Committee members, who discuss all candidate nomination materials and perform category rankings to build the slate of candidates for each election. An election announcement is sent via all communication vehicles to Section members, allowing opportunities for all members to consider running for open positions. IMGS members are also invited to participate in IMG Committees including the diversity, equity and inclusion Committee, social media, resolutions & policy, the IMG Bylaws Committee, IMGS Leadership Development; United States International Medical Graduate Liaison Committee and other ad hoc committees as deemed appropriate.

The most recent changes to the Section's IOP were made in 2021 to include the Section's policy on the GC's role in endorsing AMA Board of Trustees and Election Council Candidates each year.

The IMGS GC believed this was important for inclusivity and offering support to IMGs and other candidates. In 2023, the Section and its assigned Bylaws Committee members began working on a complete review and update of its IOP. Once this IOP has completed its revisions, it will be reviewed and approved by Section members, provided to the Council on Constitution and Bylaws and subsequently provided for the Board of Trustees' approval.

Criterion 4: Representation Threshold – Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members.

The IMGS is comprised of graduates of medical schools outside the United States or Canada as identified in the AMA Masterfile. IMGs who join the AMA automatically become members of the IMGS. The core members of the Section are those that participate in the IMGS Congress and online member forum. IMG physicians represent approximately 25 percent of the U. S. physician workforce, and the Section has a potential membership of over 324,000 physicians

Involvement in the IMGS GC, committees, meetings and events, requires that a physician be a current AMA member. Membership of the IMGS increased from 43,554 in 2019 to 53,023 when the letter of application was submitted in June 2024.

Criterion 5: Stability – The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body.

The IMGS was established in 1997 and has demonstrated consistent growth in membership and engagement. From the 2019 Annual Meeting to the 2024 Annual Meeting the IMGS averaged 153 attendees at each IMGS meeting. From 2015 to 2019 attendance at the same meetings averaged 77 members; the last five years have shown a nearly 100 percent increase in attendance over the five years prior. This substantial increase means that the deliberations of the HOD and resulting AMA policy incorporates the perspectives of a significantly increased number of IMGs.

The IMGS attributes this increased participation to continuous communication with current and potential members via newsletters, the IMGS Facebook page, surveys, emails, and specific campaigns, e.g. IMGS Recognition Week and Research Challenge, state IMG Chair Groups and ethnic societies. The Section has also collaborated with other organizations to increase engagement and membership and attended special meetings such as Project IMG—an exclusive network connecting, resourcing and supporting international medical students and graduates—to assist in this effort. This outreach has increased engagement, promoted more interest in the Section as well the AMA.

Criterion 6: Accessibility – Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the AMA HOD.

IMGs make up 7.9 percent of delegates in the AMA HOD and 10.5 percent of Alternate Delegates. Comparatively, according to CLRPD Report 1-A-23, IMGs make up 18.1 percent of AMA members and 22.3 percent of all physicians and medical students, demonstrating a significant level of underrepresentation in the AMA's policymaking body.

Through the Section, IMGs can participate in the AMA's policymaking process during business meetings, reference committee hearings and IMGS caucuses, as well as making use of the IMGS online member forum to debate and ratify resolutions submitted to annual and interim meetings. Other opportunities to contribute to AMA policymaking include participation in the Resolutions & Policy Committee, the IMGS GC (including delegate and alternate delegate positions) and other committee/webinar discussions. The IMGS also provides an opportunity for other sections and councils to provide input on resolutions being considered by the Section for annual and interim meetings, which are shared with the IMGS GC.

The Section identifies its active core members through participation in Section meetings, webinars, Facebook discussions, the AMA Members Move Medicine campaign, and others that engage in committees and mentoring activities. Additional core members include those who participate in newsletter review, online member forums, and vote in the annual GC elections, which at the time of application consisted of over 105 members and 63 mentors.

The IMGS ensures accessibility through a transparent process that aligns with the principles of equity, enhanced decision-making through diverse perspectives, addressing systemic barriers of participation and strengthening governance and policy. The Section is committed to offering a positive member experience, while increasing member engagement on IMG issues, developing new AMA resources and working with new and present partners to increase the AMA Section value and obtain actionable insights.

DISCUSSION

The IMGS continues to focus on issues pertaining to international medical graduates not only within the AMA but throughout the United States. No other existing group within the AMA specifically focuses on these issues, and the Section collaborates with other AMA units when appropriate. Over the past five years, the Section has participated, often in collaboration with other AMA units, in substantial outreach to legislative and regulatory bodies on issues and legislation relevant to all IMGs, including both houses of Congress, the Department of Homeland Security, and the Department of State, demonstrating the Section's role as an important advocate for IMGs in the United States. These efforts have contributed to a number of successes including the creation of pathways and alternative methods to ensure that IMGs receive equitable access to patient care, the addition of one thousand Medicare-funded residency slots through the Inpatient Prospective Payment System, ensuring that IMGs maintained their immigration status during the COVID-19 pandemic, and obtaining licensure parity in several states including Louisiana, Minnesota and Pennsylvania.

The initiatives of the IMGS are consistent with those of the AMA, in particular, IMGS activities focus on practice sustainability and satisfaction for IMG physicians and the patients they serve. Of equal significance, with IMGs making up approximately one-quarter of physicians in the United States, the IMGS provides the AMA with a necessary pipeline for obtaining insight on the challenges and needs of a major segment of the U.S. health care delivery system, which can then be incorporated into AMA policy and strategic planning.

The structure of the Section enables its constituents to participate in both policymaking activities and section leadership; IMGS members have numerous opportunities to actively participate in the resolution development and review to affect changes on issues significant to members of the Section. As the IMG population continues to grow, the Section provides valuable support to its members and IMGs across the country. The IMGS membership has grown by 11 percent since its previous review in 2020, and average meeting participation has nearly doubled, demonstrating both

the effectiveness of the Section's outreach efforts and the need for its continued role in AMA activities and member support. Additionally, it should be reiterated that IMGs remain significantly underrepresented when compared with all members of the HOD, demonstrating even further the need for the Section's continued voice in the AMA policymaking process to ensure that the issues of concern of IMGs have a forum to be deliberated and addressed.

The Council appreciates the thorough work of IMGS leadership and staff in completing this letter of application and follow-up communications, as well as the deliberation of the Section as it looks to improve upon its already commendable work in the future.

CONCLUSION

The CLRPD has determined that the IMGS meets all criteria; therefore, it is appropriate to renew the delineated section status of the section, allowing the continued focused representation of IMGS members in the HOD.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the International Medical Graduates Section through 2030 with the next review no later than the 2030 Annual Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 2-A-25

Subject: Organized Medical Staff Section Five-Year Review

Presented by: Michelle Berger, MD, Chair

Referred to: Reference Committee F

The Council on Long Range Planning and Development (CLRPD) analyzed information from a letter of application submitted in September 2024 from the Organized Medical Staff Section (OMSS) for renewal of delineated section status and representation in the American Medical Association (AMA) House of Delegates (HOD). The letter focused on activities beginning in June 2019.

AMA Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every five years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

APPLICATION OF CRITERIA

Criterion 1: Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

The OMSS is the recognized center of expertise within the AMA and the house of medicine for matters concerning hospital and health system medical staffs and issues facing physicians practicing within the hospital setting. Medical staff leaders, other physician members of the medical staff, hospital/health system administrators, health care law attorneys, medical staff professionals, state/specialty medical society leadership and staff, and other stakeholders look to the OMSS for guidance on these and other issues. OMSS works closely with the National Association of Medical Staffing Services (NAMSS) on credentialing and privileging issues to ensure that physician and resident interests are protected and the processes become as streamlined as possible. Colleague medical societies like the American College of Surgeons regularly seek the OMSS' advice on issues impacting OMSS members and their medical staff colleagues.

Over the past five years, OMSS has identified and worked to affect the following issues of concern:

<u>Medical staff unification and systematization</u>

Since 2014, the Medicare Conditions of Participation have permitted unification of multiple medical staffs across multi-hospital systems. The OMSS has provided comprehensive education

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and resources on this topic going back to 2014. In 2021, OMSS updated its Guide to Medical Staff Organization Bylaws, re-publishing the guide in its seventh edition. The Guide contains new sections on gender-neutral language, pandemic preparedness, right to practice, exclusion from Medicare, criminal clearance and background checks, Board certification and equivalency, and many others. The updated guide also comes with a variety of toolkits developed to provide practical illustrations of the new concepts and guidelines.

Physician-hospital relations

The OMSS has worked to reframe the relationship between physicians and hospitals as one of partners rather than adversaries, while explicitly advocating for medical staff self-governance. The AMA Guide to Medical Staff Bylaws incorporates several previously adopted OMSS resolutions designed to strengthen these perspectives as well as toolkits to help guide physicians around topics such as gender disparity, pandemic preparedness, and others. In 2022, the OMSS revised its model physician-hospital employment contract and made these available to members. The OMSS Plans to revise an additional model contract for group practices within the next two to three years.

Physician voice in development of accreditation standards

OMSS leadership regularly communicates with AMA-appointed representatives to The Joint Commission (e.g., AMA-appointed members of the Joint Commission Board of Commissioners), as well as with Joint Commission senior staff leadership. Through these interactions, the OMSS has influenced key decisions on Joint Commission hospital accreditation matters. OMSS has also worked to expand physician influence in accreditation matters by engaging AMA members in Joint Commission field reviews and related opportunities.

Support for physicians during hospital closures

When Philadelphia's Hahnemann University Hospital closed in September of 2019, it left more than five hundred residents and fellows without an accredited program they could use to continue their medical education. The OMSS was a key player in drafting policy and resolutions to protect physicians affected by Hahnemann's closure and establish a playbook for the closure or significant reduction in services of hospitals in the future. Those actions included working with other stakeholder organizations to develop proactive processes in the event of sudden teaching hospital closures and promoting funds from health care facilities that ensure professional liability coverage in the event of closures.

Connecting physicians to the personal protective equipment they needed during Covid-19

As the COVID-19 pandemic surged in 2020, physicians across the country were left with substandard options for obtaining and maintaining personal protective equipment. The OMSS was the key initiator of a partnership with a non-profit, Project N95, to coordinate efforts to provide physicians with the masks, face shields, and other products they needed to maintain their safety in the face of the pandemic.

Support for physician collective action

Unionization and collective action have grown as areas of interest for OMSS members, partially spurred on by the COVID-19 pandemic. OMSS members have expressed a desire to better understand how collective action can be accomplished relative to the obligations of the practice of medicine. Since 2022, the Section has sponsored two webinars focused on developing a critical

understanding of how collective bargaining and action works in a medical setting and has advanced two resolutions directing the AMA to develop policies and procedures around physician collective action. The efforts to provide education and perspective building are ongoing.

Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

OMSS aligns its focus areas and activities with AMA's strategic priorities. The OMSS has a two-fold mission: To improve the practice experience, and, by doing so, to positively impact patient outcomes. OMSS advocates for physicians and medical staff by removing obstacles to patient care and improving engagement, while also reporting key challenges to the AMA. Medical staff feedback has led to the creation of multiple resolutions adopted by the Section and advanced to the HOD on better compensation for time spent on prior authorization, creating stronger protections against adverse effects from corporate buyouts of practices, and fighting scope creep by improving patient awareness of care delivered through non-physician extenders. In all, the OMSS has sponsored nearly forty resolutions since its last review in 2019, making significant impact on AMA policy and the Association's strategic direction.

OMSS-member medical staffs and their physicians will continue to be significant players in determining how the transition from a volume-based to a value-based care delivery and payment system is managed in the United States. Chronic disease is tailor-made for a value-based environment because it is managed rather than cured. As the entities responsible for patient care quality and safety within health facilities, medical staffs and their physicians are positioned to substantially and positively impact a patient's long-term health status in the management of one or more chronic diseases, while input from OMSS-member medical staff representatives will continue to assist in guiding the AMA's work in this critical area.

Criterion 3: Appropriateness – The structure of the group will be consistent with its objectives and activities.

Section members have a wide range of opportunities to participate in the activities of the OMSS. Although annual and interim meetings are the most obvious of these opportunities, the Section actively promotes that one need not attend meetings to contribute to the work of the Section and provides a variety of opportunities for engagement between meetings, including:

- OMSS committees (e.g., Education Committee, Policy Committee, Membership and Engagement Committee)
- The online member forum enables all representatives to contribute to the policymaking activities of the Section, regardless of whether they can attend meetings.
- Participation in the Section's Reference Committee and Late Resolution Committee for both annual and interim meetings
- Surveys to gauge representatives' interest in potential topics for future education programs and provide a voice to representatives in the Section's strategic planning activities
- Peer-to-peer outreach program for representatives who wish to contribute to the Section's recruitment efforts
- Calls to action on vital legislative and regulatory issues (e.g., Joint Commission field reviews)
- Monthly newsletters (sent to approximately 1,400 subscribers) with relevant medical staff news and announcements.

Criterion 4: Representation Threshold – Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members.

Since the Section's last renewal of delineated section status, the OMSS has seen an increase of 17 representatives, reaching 178 by September 2024, an increase of 10.6 percent from the 161 OMSS representatives certified in 2019. The Section estimates that it now directly represents approximately 4,000 AMA member physicians based on the following assumptions:

- Approximately 15 percent of practicing physicians are currently AMA members,
- The average medical staff size is 150, and
- There is minimal staff membership overlap between represented hospitals.

By comparison, using the same calculation, OMSS covered 3,600 AMA member physicians in 2019, showing a steady increase in participation.

The total number of AMA member physicians who could potentially be represented in OMSS is uncertain, as the AMA has no robust data on how many members have been appointed to at least one hospital/health system medical staff. However, using a conservative estimate that 60 percent of all practicing physicians (i.e., not including medical students, residents, or retired physicians) are part of at least one medical staff, and referencing CLRPD's 2023 demographic report, the total potential representation in the OMSS is approximately 88,543 AMA practicing physician members.

Criterion 5: Stability – The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body.

Since its inception in 1983, the OMSS has played a vital role in helping the AMA address matters concerning hospital and health system medical staffs and issues facing physicians, whether employed or in private practice, who practice within the hospital setting.

Since its last five-year review, OMSS meetings held in conjunction with AMA annual and interim meetings have averaged 37 credentialed representatives and 68 total attendees. OMSS measures meeting participation with two metrics: (1) Section members credentialed to vote at the meeting, and (2) all meeting attendees, regardless of member/voting status. This distinction is made because OMSS typically draws non-OMSS-member attendees to its education programs and other non-business activities at each annual and interim meeting (e.g., individuals from stakeholder organizations such as The Joint Commission, the NAMSS, federation staff, health law attorneys, etc.). OMSS meeting participation has fluctuated over the last five years, due in large part to the effects of the COVID public health emergency.

The OMSS traditionally has communicated with its members and other individuals interested in medical staff topics through a monthly email newsletter with approximately 1,400 subscribers. In 2017, the OMSS launched a Facebook group and continues to post updates on joining, running for the Governing Council (GC) and promoting webinars. Facebook currently has 289 members, up from 210 from the 2019 report and provides a platform for members to discuss relevant topics, stay connected personally, and provides another communication link for AMA announcements. Finally, the Section created a GroupMe chat allowing members to discuss important topics including activities by peers not in the OMSS.

Criterion 6: Accessibility - Provides opportunity for members of the constituency, who are otherwise under-represented, to introduce issues of concern and to be able to participate in the policymaking process within the HOD.

The OMSS offers a unique perspective on the relationship between physicians (whether independent or employed) and the health systems in which they provide services and provides a crucial link between physicians and the facilities where they practice, filling a niche that might not be available to physicians elsewhere. The OMSS serves as an entry point for most resolutions addressing medical staff and hospital issues, which directly affect a large percentage of AMA delegates. On average, the OMSS submits five to seven resolutions for the consideration of the HOD at each meeting, greater than 90 percent of which are eventually adopted in some form. Most OMSS resolutions are introduced by individual Section representatives who, through the experiences of the medical staffs they represent, have identified pressing needs for AMA policy or action. Additionally, resolutions are introduced by OMSS representatives acting on behalf of their state level OMSS groups whose medical societies are not well positioned to address the identified problem.

At the beginning of 2023, the OMSS established an Employed Physicians Caucus to provide advice and counsel to the OMSS and to AMA staff on policy matters that bear directly on employed physicians and their patients. The current roster has an active population of 28 physicians who add to the potential representation of the OMSS. The Caucus convenes two meetings per year, held in conjunction with the annual and interim meetings of the HOD, with additional meetings scheduled throughout the year as necessary. Starting at the 2024 Interim Meeting, the Employed Physician Caucus joined the OMSS Policy Committee for its handbook review.

In addition to providing an opportunity for members to introduce issues of concern, the Section reviews resolutions and reports under consideration at each meeting and, in a democratic process led by the GC, determines which items the Section should take positions on, and what those positions should be. Additionally, the OMSS provides its members with an opportunity to become involved in the Section's HOD activities, such as providing testimony on behalf of the Section at reference committee hearings. The OMSS holds a briefing/strategy session before the Sunday-morning HOD reference committee hearings and a post-reference committee hearing debriefing, both of which are open to all OMSS representatives and other AMA members interested in medical staff matters.

DISCUSSION

The OMSS provides a voice for staff physician interests, as the evolution of staff structures and functions continues to change the landscape of hospital medical staffs. The Section is uniquely focused on addressing the needs and issues of physicians on medical staffs. Through wide-ranging activities, the OMSS strives to improve medical staff relations and empower physicians to lead, direct, and ensure the success of those staffs. The OMSS is in alignment with the AMA's strategic foci, evidenced by the Section's efforts to remove barriers to patient care and joy in medical practice, treat chronic diseases and remove inequities in health care, and provide opportunities for its members to enhance their participation in AMA activities and deliberations.

As physician modes of practice continue to evolve, it is increasingly vital for the AMA to have a conduit to employed physicians, who are now the majority stakeholder in the physician population. The Section's development and incorporation of its Employed Physicians Caucus established a direct path for the needs and priority issues of employed physicians to be incorporated into OMSS, and, subsequently, the AMA's policy and strategic decision-making. This development also

demonstrated the Section's desire and ability to evolve within the changing landscape of health care delivery and willingness to adapt to the needs of its constituents. In addition to the fact that a majority of AMA members are likely to be members of at least one medical staff, the OMSS representatives themselves represent thousands of AMA members in their own medical staffs. The OMSS has demonstrated strong continuity since its founding over 40 years ago.

The unique relationship between physician staffs and organizations incorporates many issues and the OMSS is an appropriate means for members to focus on and address these topics in a holistic fashion and create needed policy. The OMSS provides a crucial link between physicians and the facilities where they practice, and the Section provides the necessary perspective for members to address critical issues related to physician and hospital matters.

The Council appreciates the thorough work of OMSS leadership and staff in completing this letter of application and follow-up communications, as well as the deliberation of the Section as it looks to improve upon its already commendable work in the future.

CONCLUSION

The CLRPD has determined that the OMSS meets all required criteria; therefore, it is appropriate to renew the delineated section status of the OMSS.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Organized Medical Staff Section through 2030 with the next review no later than the 2030 Annual Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500

REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report, June 2025

Subject: REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Presented by: Evelyn Lewis, MD, Chair

Referred to: Reference Committee F

BACKGROUND

At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on Trustee Compensation, currently named the Committee on Compensation of the Officers (the "Committee"). The Officers, defined in the American Medical Association's (AMA) Constitution and Bylaws, consist of all 21 members of the Board of Trustees, including the President, President-Elect, Immediate Past President, Secretary, and Speaker and Vice Speaker of the HOD, and are collectively referred to in this report as Officers. The composition, appointment, tenure, vacancy process and reporting requirements for the Committee are covered under the AMA Bylaws. Bylaw 2.13.4.5 provides:

> The committee shall present an annual report to the House of Delegates recommending the level of total compensation for the Officers for the following year. The recommendations of the report may be adopted, not adopted, or referred back to the committee, and may be amended for clarification only with the concurrence of the committee.

At A-00, the Committee and the Board jointly adopted the American Compensation Association's definition of "Total Compensation" which was added to the Glossary of the AMA Constitution and Bylaws. Total Compensation is defined as the complete reward/recognition package awarded to an individual for work performance, including: (a) all forms of money or cash compensation; (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

Since the inception of this Committee, its reports have documented the process the Committee follows to ensure that current or recommended Officer compensation is based on sound, fair, cost-effective compensation practices as derived from research and use of independent external consultants, expert in Board compensation. Reports beginning in December 2002 documented the principles the Committee followed in creating its recommendations for Officer compensation.

METHODOLOGY

The Committee recently commissioned Willis Towers Watson (WTW), a major compensation consulting firm with expertise in board compensation, to review the Speaker and Vice Speaker Governance Honorariums and consider if a separate larger Honorarium would better recognize the considerable amount of work required of these positions and that the work is different from regular board members. As a result of this review, the Committee also considered if the Per Diem for Internal Representation should be eliminated for all non-leadership board members.

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FINDINGS

WTW analyzed the Speaker and Vice Speaker compensation data for the past three terms, 2021/2022, 2022/2023 and 2023/2024. The analysis demonstrated that the Speaker and Vice Speaker roles require a significant time commitment given the volume of work required of each. Based on the analysis, WTW supports a higher honorarium of $125,000 for the Speaker and $115,000 for the Vice Speaker. The increased honorarium would cover all internal representation.

In addition, WTW's analysis also raised questions about the need for a Per Diem for Internal Representation for non-leadership board members. The current Governance Honorarium includes 11 days of internal representation per term. Review of the past three terms showed all board members except the Speakers (and only once for one board member and one medical student) were under the 11 days that are compensated by the Governance Honorarium as currently defined. This Committee recommends eliminating the Internal Representation for all board members and revising the Governance Honorarium definition for all non-officer board members to state that all internal representation days are included in the Honorarium, resulting in a per diem only for External Representation, thus providing greater clarity and simplification of Board compensation.

RECOMMENDATIONS

The Committee on Compensation of the Officers recommends the following recommendations be adopted effective July 1, 2025, and the remainder of this report be filed:

1. That the Governance Honorarium for the Speaker and Vice Speaker be increased to $125,000 and $115,000 respectively and include all internal representation days.

2. That the definition of the Governance Honorarium be revised as follows:

   The purpose of this payment is to compensate Officers, excluding Board Chair, Chair-Elect and Presidents, for all Chair-assigned internal AMA work and related travel. This payment is intended to cover the yearly slate of meetings as approved by the Board, which include: Board meetings and additional meetings including but not limited to: State Advocacy Summit, National Advocacy Conference, and Annual and Interim meetings; special Board or Board committee, subcommittee and task force meetings**;** Board orientation, Board development and media training**;** and Board conference calls. This includes any associated review or preparatory work, and all travel days related to all such meetings. The Governance Honorarium also covers all internal representation, such as section and council liaison meetings, any associated review or preparatory work, and all travel days related to all such meetings. ~~The Governance Honorarium also covers Internal Representation, such as section and council liaison meetings (and associated travel) or calls, up to eleven (11) Internal Representation days.~~

3. That the definition of the Per Diem for External Representation and the related Telephonic Per Diem Representation be revised as follows:

   The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is ~~either~~ external to the AMA, or organizations with which the AMA has a key role in creating/partnering/facilitating, achievement of the respective organization goals such as the AMA Foundation. ~~PCPI, etc. or for Internal Representation days above eleven (11).~~ The Board Chair may also approve a per diem for special circumstances

that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is $1,550 per day.

Definition of Telephone Per Diem for External Representation ~~effective July 1, 2017~~:

Officers, excluding the Board Chair and the President(s), who are assigned by the Board Chair as the AMA representative to outside groups as one of their specific Board assignments ~~or assigned Internal Representation days above eleven (11)~~, receive a per diem for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for those meetings would require the approval of the ~~Chair of the~~ Board Chair. The amount of the Telephonic Per Diem will be ½ of the full Per Diem which is $775.

4. That the remainder of the report be filed.

Fiscal Note: minimal

APPENDIX

Board Leadership Compensation

POSITION	**GOVERNANCE HONORARIUM**
President	$298,865
Immediate Past President	$290,659
President-Elect	$290,659
Chair	$285,886
Chair-Elect	$211,630

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(A-25)

Introduced by: American College of Lifestyle Medicine, Minority Affairs Section

Subject: AMA To Develop Patient Educational Materials Regarding Ultra-processed Foods for Distribution by AMA members

Referred to: Reference Committee F

Whereas, poor dietary practices are recognized as a major contributor of non-communicable diseases and identified top dietary factors as diets high in sodium and low in whole plant foods (i.e., whole grains, fruits, nuts and seeds and vegetables);[1] and

Whereas, poor diet is responsible for more deaths globally than tobacco, high blood pressure or any other health risk;[1] and

Whereas, dietary habits account for one in every five deaths globally;[1] and

Whereas, the Standard American Diet is low in whole plant foods but high in red and processed meats, fat, sodium, ultra-processed foods, added sugar and calories and contributes to an overall increase in chronic disease and the US obesity epidemic;[2] and

Whereas, food processing is the alteration of a raw ingredient from its natural state to one where desirable nutrients are removed or destroyed and/or undesirable nutrients are added and may have negative or positive effects on overall health status;[3] and

Whereas, ultra-processed foods are made through industrial methods/techniques and include any foods that are modified with artificial colors and flavoring, emulsifiers, preservatives, added fat, salt or sweeteners;[4] and

Whereas, from natural foods and tend to have undesirable additives that would not otherwise be used in homemade food preparation - supplemented ingredients such as added sugar, artificial sweeteners, hydrogenated oils, nitrites, fats, artificial colors and preservatives;[4] and

Whereas, additives and preservatives in ultra-processed foods have been associated with increased incidence of auto immune illness, gut microbiome dysbiosis, and hyper palatability by improving food appearance and taste;[4] and

Whereas, ultra-processed foods contribute to 70% of sodium intake in US foods coming from purchased foods and restaurant foods and make up about 60% of energy intake;[5] and

Whereas, ultra-processed foods intake leads to greater consumption of refined carbohydrates, added sugars, saturated fats and sodium (i.e., markers of poor diet quality associated with cardiovascular disease, obesity and hypertension);[6] and

Whereas, ultra-processed foods consumption leads to a greater risk of a diet lacking in essential nutrients (i.e., dietary fiber, zinc, potassium, phosphorus, magnesium, calcium and vitamins A, C, D and E);[6] and

Whereas, each 10-gram increase in daily fiber intake results in a 10% decreased risk of all-cause mortality;[7] and

Whereas, ultra-processed foods consumption is associated with long-term weight gain as obesity via excess calories (about 500kcal per day) from carbohydrates and fats and weight gain of about 2 lbs. after 2 weeks;[8] and

Whereas, each additional daily serving of ultra-processed foods is associated with a 9% increased risk of cardiovascular disease mortality;[9] and

Whereas, ultra-processed foods consumption has been shown to be directly associated with high all-cause mortality;[10] and

Whereas, modification of ultra-processed foods consumption is possible through lifestyle changes in dietary content and nutritional behavior and can reduce and even reverse the signs and symptom of chronic diseases (such as diabetes, hypertension, hypercholesterolemia, metabolic syndrome, cardiovascular disease and others);[11-12] and

Whereas, modification of ultra-processed foods consumption is best accomplished through a collaborative relationship between a committed, trusting patient and knowledgeable, caring practitioner;[13] and

Whereas, all American Medical Association members will have the occasion to counsel and educate laypersons and patients about avoidance or reversal of dietary consumption of ultra-processed foods; therefore be it

RESOLVED, that for all American Medical Association-sponsored receptions or meals, our AMA will offer food options of minimally processed fiber-rich foods and that AMA meeting staff will work with select organizations of the HOD to develop such options; (Directive to Take Action); and be it further

RESOLVED, that our AMA work with select organizations in the HOD to develop patient educational materials in English and Spanish with regards to the health impact of ultra-processed foods as well as pathways for personal dietary options as alternatives to ultra-processed foods; and, that such developed materials will be provided by the AMA to members who request them for distribution to their patients. (Directive to Take Action)

Fiscal Note: $65,179 annually to develop educational materials

Received: 4/18/25

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RELEVANT AMA POLICY

AMA Support for Nutrition Research H-150.921

1. Our American Medical Association will support additional funding for National Institutes of Health's (NIH's) Office of Nutrition Research (ONR) to enable ONR to secure the leadership, organizational structure, and resources to effectively fulfill its important mission.
2. Our AMA encourages the NIH to prioritize research with maximal applicability to human health conditions, and that it seek input from physicians and the public regarding research priorities and maintain transparency in its planning processes.

Reduction in Consumption of Processed Meats H-150.922

Our AMA supports:
1. reduction of processed meat consumption, especially for patients diagnosed or at risk for cardiovascular disease, type 2 diabetes, and cancer;
2. initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition;
3. public awareness of the risks of processed meat consumption; and
4. educational programs for health care professionals on the risks.

Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake H-150.929

1. Our American Medical Association calls for a step-wise, minimum 50% reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade.
2. Our AMA urges the FDA to publish future editions of their voluntary targets expeditiously to make further progress on sodium reduction.
3. Our AMA supports federal, state, and local efforts to set robust targets for reducing sodium levels in school meals, meals in health care facilities, and other meals provided by daily meal providers.
4. Our AMA will advocate for federal, state, and local efforts to reduce sodium levels in products from food manufacturers and restaurants to the greatest extent possible, without increasing levels of other unhealthy ingredients, such as added sugars or artificial ingredients.
5. Our AMA supports federal, state, and local efforts to require front-of-package warning labels for foods that are high in sodium based on the established recommended daily value.
6. Our AMA will assist in achieving the Healthy People 20302010 goal for sodium consumption, by will working with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, Academy of Nutrition and Dietetics, and other interested partners to educate consumers about the benefits of reductions in sodium intake and other dietary approaches to reduce hypertension.
7. Our AMA supports the continuing education of physicians and other members of the health care team on counseling patients on lifestyle modification strategies to manage blood pressure, advocating for culturally relevant dietary models that reduce sodium intake.
8. Our AMA recommends that the FDA consider all options to promote reductions in the sodium content of processed foods.
9. Our AMA supports further study and evaluation of national salt reduction programs to determine the viability, industry engagement, and health and economic benefits of such programs.

10. Our AMA supports federal, state, and local efforts to regulate advertising of foods and products high in sodium, especially advertising targeted to children.

Accurate Reporting of Fats on Nutritional Labels H-150.939
1. Our AMA urges the Food and Drug Administration to require the use of more precise processes to measure the fat content in foods, particularly trans fats and saturated fats, and to require that the most accurate fat content information based on these processes be included on food labels.

Healthful Food Options in Health Care Facilities H-150.949
1. Our American Medical Association encourages healthful food options be available, at reasonable prices and easily accessible, on the premises of health care facilities. Providing a variety of healthy food, including plant-based meals, and meals that are low in saturated and trans-fat, sodium, and added sugars. Eliminating processed meats from menus

Irradiation of Food H-150.961
1. It is the policy of the AMA to: (1) affirm food irradiation as a safe and effective process that increases the safety of food when applied according to governing regulations; and
2. consider the value of food irradiation to be diminished unless it is incorporated into a comprehensive food safety program based on good manufacturing practices and proper food handling, processing, storage, and preparation techniques.

Addressing Adult and Pediatric Obesity D-440.954
1. Our American Medical Association will:
· Assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations.
· Encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations.
· Continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3. Our AMA will work with interested national medical specialty societies and state medical associations to increase public insurance coverage of and payment for the full spectrum of evidence-based adult and pediatric obesity treatment.
4. Our AMA will:
· work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment.
· work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.
4. Our AMA will leverage existing channels within AMA that could advance the following priorities:
Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.
Advocacy efforts at the state and federal level to impact the disease obesity.
Health disparities, stigma and bias affecting people with obesity.
Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
Increasing obesity rates in children, adolescents and adults.
Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices.
5. Our AMA will conduct a landscape assessment that includes national level obesity prevention and

treatment initiatives, and medical education at all levels of training to identify gaps and opportunities where AMA could demonstrate increased impact.
6. Our AMA will convene an expert advisory panel once, and again if needed, to counsel AMA on how best to leverage its voice, influence and current resources to address the priorities listed in item 5 above.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(A-25)

Introduced by: American Thoracic Society

Subject: Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations

Referred to: Reference Committee F

Whereas, our American Medical Association Board of Trustees is reverently and uniquely positioned to uphold the principles and tenets of science and public health, and is entrusted to act on behalf of American physicians; and

Whereas, in existing policy and practice the Board of Trustees sets strategic direction and legislative priorities for report in the Interim Meeting, with the option to take action in between HOD Meetings in urgent situations; and

Whereas, current policy G-600.071 and current practice yield authority to BOT on AMA action in urgent situations, and further allow BOT to make a determination of what it deems best represent the interests of patients, physicians, and the AMA; however, current policy and practice do not require BOT take action in times of national or global crises to health or science; and

Whereas, the 2020 public health emergency of COVID-19 highlighted the need for AMA, particularly AMA leadership and the BOT, to reassess priorities and respond expediently to urgent needs; and

Whereas, in 2025 the first 100 days of the 2nd term for President Donald J. Trump has led to substantial and unprecedented challenges to the structures of science and American health, with many major national institutions and agencies voicing their positions on issues of importance to human health; and

Whereas, the actions of the current federal administration have caused affronts to the core of science and health system funding, policies, and institutions, and have caused disruptions to the healthcare workforce; and

Whereas, the actions of the current administration intend to continue toward cataclysm of fundamental health structures, including but not limited to

(1) disrupting the economic support for evidence-based medicine, which preserves the integrity of scientific inquiry and an open platform for discovery beyond corporate funded research;
(2) reducing the government's contributions to US health care expenditures, which are currently at approximately half (~$2.2 trillion) of total US health care expenditures[1], and upon which our US healthcare systems and hospitals are financially dependent;
(3) challenging the US health care workforce, of which 18.2% are foreign-born, including 26.5% of physicians being foreign-born[2], and its pipeline for creating healthcare workers that mirror the communities they serve, which research shows improves health care in minority populations[3];

(4) disrupting the pipeline of talent for scientific research, as 38.6% of US master's and postdoctoral students in science, engineering, and health are temporary visa holders[4], therefore creating vulnerability to the US scientific research industry, which as of 2023 has an estimated market impact of $320 billion in revenue, substantially due to a historic recognition of and reliance on foreign-born scientific labor and experts[5]; and
(5) discrediting the US as a global leader for using evidence-based findings to drive medical decisions, public policies, and research funding; and

Whereas, AMA advocacy is influential for the trajectory of American health care; and

Whereas, in conditions of transformational affronts to the policies and structures that enable our modern systems and foundational institutions for science and health, we require our AMA advocacy; and

Whereas, in such moments, the AMA HOD and physician members are reliant on the voice of our Board of Trustees to act - responsibly, clearly, and expediently; therefore be it

RESOLVED, that our American Medical Association amend G-600.071, "Actions and Decisions by the AMA House and Policy Implementation" to read

- 3. Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. ~~Further,~~
- 4. In urgent situations, the Board of Trustees ~~has the~~ will exercise its authority to take such action as it determines is appropriate ~~in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians, and the AMA.~~ to advocate for science and public health**.** In representing AMA policy in critical situations, the Board will take into consideration existing AMA policy, recommendations from AMA policy staff, and input solicited or obtained from the House of Delegates or its Councils and Sections to inform its position on the interests of patients, physicians, and the AMA. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.

~~4.~~ 5. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA considers transformational occurrences, including public health phenomena, sudden changes to national health policies, and sudden disruptions of health and science funding, to be urgent situations worthy of AMA Board of Trustee advocacy and action (New HOD Policy); and be it further

RESOLVED, that our AMA considers sudden federal funding cuts to foundational institutions of science research and public health to be urgent situations and requests the Board of Trustees take immediate action to respond responsibly, clearly, and expediently as an advocate for science, health care, and public health. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/25

REFERENCES
[1] Peter G. Peterson Foundation. "Healthcare Spending Will be One-Fifth of the Economy within a Decade." Updated Sept 16, 2024. Accessed 4/21/2025 at https://www.pgpf.org/article/healthcare-spending-will-be-one-fifth-of-the-economy-within-a-decade.
[2] Migration Policy Institute. "Immigrant Health-Care Workers in the United States." April 7, 2023. Accessed 4/21/2025 at https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states-2021.
[3] Silver JK, Bean AC, Slocum C, et al. Physician Workforce Disparities and Patient Care: A Narrative Review. Health Equity. 2019;3(1):360-377.
[4] National Science Foundation: National Center for Science and Engineering Studies. "Graduate Enrollment and Postdoctoral Appointments in Science, Engineering, and Health Rise, Driven Largely by Increases in the Number of Women and Temporary Visa Holders." January 21, 2025. Accessed 4/21/2025 at https://ncses.nsf.gov/pubs/nsf25316.
[5]Walsh B. "The self-inflicted death of American science has already begun." *Vox.* Apr 9 2025.

RELEVANT AMA POLICY

Annual Reporting Responsibilities of the AMA Board of Trustees G-605.050
Our American Medical Association Board provides the following four items to the AMA House:

1. At each Annual Meeting of the House, the Board submits a report to the House that provides highlights on the AMA's performance, activities, and status in the previous calendar year as well as a recommendation for the Association's dues levels for the next year. The report should include information on topics such as:
    a. AMA's performance relative to its strategic plan.
    b. Key indicators of the AMA's financial performance and, if not provided through other communication vehicles, information on the compensation of Board members, elected Officers, the Executive Vice President, and the expenses associated with the AMA Councils, Sections, Special Groups, and AMA's participation in the World Medical Association.
    c. An assessment of the performance, accomplishments, and activities of the Board, including the AMA appearance program and the results of the work of the Board's Audit Committee.
    d. AMA's membership situation, including an assessment of the membership communication and promotion activities;
    e. Highlights of the activities and accomplishments of the Association's major programs, including legislative and private sector advocacy.
    f. A description and assessment of efforts to address high priority issues.
    g. The AMA's relationships and work with other organizations, including Federation organizations, other health related organizations, non-health related organizations, and international organizations.

The Board may include any other topics in this report that it deems important to communicate to the House about the performance, activities, and status of the AMA and the health of the public.

2. As the principal planning agent for the AMA, the Board provides a report at each Interim Meeting of the House that recommends the AMA's strategic directions and plan for the next year and beyond. The report should include a discussion of the AMA's membership strategy.
3. At each Interim Meeting, the Board provides an informational report on the AMA's legislative and regulatory activities, including the Association's accomplishments in the previous 12 months and a forecast of the legislative and regulatory issues that are likely to occupy the Council on Legislation and other components of the AMA's for the next year.

In fulfilling its responsibilities to report to the House on topics and situations, the Board should provide succinct reports to the House. When detailed information on topics is warranted, the Board should

provide the information to interested members of the House through reports that can be downloaded from the AMA web site.
Nothing in this policy precludes the House from requesting that the Board report back to the House on any topic. Further, nothing in this policy should be construed as limiting the number or size of reports that the Board can send to the House.
Sub. Res. 52, A-74 Res. 57, A-81 Reaffirmed: CLRPD Rep. C, A-89 Sub. Res. 83 and 125, A-90 Reaffirmed: CLRPD Rep. F, I-91 Modified by Res. 609 Reaffirmed by 610 and 611, I-94 Res. 622, I-97 Appended by Rep. of the Ad Hoc Cmte. to Study the Sunbeam Matter and Res. 617, A-98 Res. 609, I-99 Reaffirmed: Sunset Report, I-00 Consolidated: CLRPD Rep. 3, I-01 Appended: Rep. of the Ad Hoc Cmte. on Governance and Res. 618, A-02 Modified: CLRPD Rep. 1, A-03 Modified: BOT Rep. 1, I-03 Modified: CCB/CLRPD Rep. 3, A-12 Reaffirmed: CCB/CLRPD Rep. 1, A-22

AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959

1. Our American Medical Association opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.
2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:
    a. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
    b. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
    c. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
    d. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.
    Res. 523, A-06Appended: Res. 706, A-13Reaffirmed: Res. 250, A-22

Actions and Decisions by the AMA House and Policy Implementation G-600.071

1. AMA policy on House actions and decisions includes the following:
A. Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (i) correcting factual errors in AMA reports, (ii) rewording portions of a report that are objectionable, and (iii) rewriting portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible.
B. A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be amended by means of a positive action of the House specifically intended to change that policy.
C. Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.
2. AMA policy on implementation of policy includes the following:
A. Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and report recommendations and specific actions that have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted.
B. Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions.
C. Any resolution which is adopted by our AMA House remains the policy of the Association until amended, rescinded or sunset by the House.

3. Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. Further, the Board of Trustees has the authority in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians, and the AMA. In representing AMA policy in critical situations, the Board will take into consideration existing policy. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.
4. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(A-25)

Introduced by: Minority Affairs Section

Subject: Renaming the Minority Affairs Section to the Underrepresented in Medicine Advocacy Section

Referred to: Reference Committee F

Whereas, the Minority Affairs Section (MAS) was officially established in 2010 to provide a dedicated voice within the AMA for learners, trainees, and physicians from historically marginalized and underrepresented communities, and has played a critical role in advancing health equity, workforce diversity, and inclusion in organized medicine; and

Whereas, the term "underrepresented in medicine" (UIM) is widely recognized by national medical organizations, including the AAMC, as a more precise and inclusive term that better reflects the systemic barriers faced by physicians and trainees from marginalized backgrounds[1]; and

Whereas, renaming MAS to the Underrepresented in Medicine Advocacy Section (UMAS) ensures that the section's name accurately reflects its mission to advocate for physicians, trainees, and patients who experience systemic exclusion and health inequities; and

Whereas, this name change aligns with AMA's ongoing efforts to promote equity, increase physician representation from underrepresented groups, and strengthen advocacy for minoritized communities[2,3]; therefore be it

RESOLVED, that our American Medical Association Minority Affairs Section (MAS) be renamed the Underrepresented in Medicine Advocacy Section (UMAS). (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

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1. Association of American Medical Colleges. Equity, Diversity, & Inclusion. https://www.aamc.org/about-us/equity-diversity-inclusion. Accessed March 23, 2025.
2. American Medical Association. The AMA's commitment to workplace diversity, equity and inclusion. Published February 27, 2025. https://www.ama-assn.org/about/ama-career-opportunities/ama-s-commitment-workplace-diversity-equity-and-inclusion. Accessed March 23, 2025.
3. American Medical Association. Equity, diversity and belonging in medical education. Published January 14, 2025. https://www.ama-assn.org/education/changemeded-initiative/equity-diversity-and-belonging-medical-education. Accessed March 23, 2025.

RELEVANT AMA POLICY

Minority Affairs Section B-7.7
7.7 Minority Affairs Section. The Minority Affairs Section is a delineated Section.
7.7.1 Membership. All active members of the AMA, including residents and fellows and medical students, who express an interest in racial or ethnic minority issues shall be eligible for membership in

the Minority Affairs Section. Physicians or medical students who are not AMA members may join the Section for up to 2 years as provisional members without the right to vote.
7.7.2 Elections. Membership on the Governing Council shall be determined through election by members of the Minority Affairs Section. All members of the Minority Affairs Section, except provisional members, shall be entitled to vote in elections of Governing Council members. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.
7.7.2.1 Election of Officers. The Governing Council shall elect its Chair and Vice Chair from among the Governing Council members.
7.7.3 Cessation of Membership. If an officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.7.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant.
7.7.3.1 Section Representatives on the Governing Council. Section Representatives on the Governing Council. If a representative of the Resident and Fellow Section or Young Physicians Section ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of the respective section. If a representative of the Medical Student Section graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.
7.7.3.2 Section Representative as Immediate Past Chair. A Section representative who has been elected as chair of the Governing Council, but who ceases to meet the criteria for membership in the section from which elected during their term as Immediate Past Chair, shall be permitted to complete the term of office, as long as the officer remains an active physician member of the AMA.

H-350.978 Minorities in the Health Professions
The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.
(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.
(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.
(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.
(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.
(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.
(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.
(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18]

H-350.971 AMA Initiatives Regarding Minorities
The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the

development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components:
(1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine;
(2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities;
(3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;
(4) Response to inquiries and concerns of minority physicians and medical students; and
(5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine. [CLRPD Rep. 3, I-98; CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(A-25)

Introduced by: Medical Student Section, American Association of Public Health Physicians, American College of Physicians, Minority Affairs Section

Subject: Advisory Committee on Tribal Affairs

Referred to: Reference Committee F

Whereas, there has been an exponential increase in the number of policies adopted or amended by the AMA House of Delegates, focused on improving the health of the American Indian and Alaska Native (AI/AN) population[1]; and

Whereas, American Medical Association staff has reported insufficient internal expertise to implement HOD-passed policies specific to AI/AN Tribes and Villages, and the Indian Health Service, due to a limited understanding of the federal trust responsibility[2]; and

Whereas, the 574 federally recognized AI/AN Tribes across the U.S. have distinct languages, traditions, and health needs, reflecting their sovereign status and a government-to-government relationship with the federal government rooted in the U.S. Constitution, treaties, laws, and executive orders[3-4]; and

Whereas, addressing the unique political, legal, and socioeconomic factors influencing AI/AN health outcomes requires specialized approaches beyond those applied to marginalized communities in general[5-6]; and

Whereas, establishing an AMA Advisory Committee on Tribal Affairs, composed of physicians, residents, and medical students with expertise in AI/AN health, would provide essential guidance to the Board of Trustees on implementing policies affecting AI/AN physicians, medical students, patients, and communities, while complementing—though not replacing—the direct involvement of the Association of American Indian Physicians and the Indian Health Service in the AMA House of Delegates; and

Whereas, tribal governments manage most Indian Health Service facilities, emphasizing the need for diverse perspectives to advise the AMA Board of Trustees[7]; therefore be it

RESOLVED, that our American Medical Association: (1) establish an Advisory Committee on Tribal Affairs composed of AMA members who themselves identify as American Indian and Alaska Native (AI/AN) or have direct experience or close professional relationships with AI/AN communities (e.g., members of Association of Native American Medical Students and Association of American Indian Physicians) or the Indian Health Service to advise the Board of Trustees on how to implement policy specific to AI/AN communities; and (2) promote and foster educational opportunities for AMA members and the medical community to better understand the contributions of AI/AN communities to medicine and public health, including cultivating a rich understanding and appreciation of AI/AN perspectives on health and wellness. (Directive to Take Action)

Fiscal Note: $74,321 Annual Cost

Date Received: 04/10/2025

REFERENCES

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2. AMERICAN MEDICAL ASSOCIATION BOARD OF TRUSTEES MEETING SUMMARY AND HIGHLIGHTS. American Medical Association. Published online September 11, 2022. https://www.ama-assn.org/about/board-trustees/board-trustees-actions-official-record
3. IHS Profile. Indian Health Service. Published online August 2020. https://www.ihs.gov/newsroom/factsheets/ihsprofile/
4. Government-to-Government Relations with Native American Tribal Governments. Published online April 29, 1994. https://www.doi.gov/pmb/cadr/programs/native/Government-to-Government-Relations-with-Native-American-Tribal-Governments
5. General Principles of Federal Indian Law. University of Alaska Fairbanks. Published online 2016. https://www.uaf.edu/tribal/academics/112/unit-4/generalprinciplesoffederalindianlaw.php#:~:text=Government%2Dto%2DGovernment%20Relationship%3A,than%20one%20based%20on%20race
6. Warne D, Frizzell LB. American Indian health policy: historical trends and contemporary issues. Am J Public Health. 2014;104 Suppl 3(Suppl 3):S263-S267. doi:10.2105/AJPH.2013.301682
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RELEVANT AMA POLICY

Advocacy for Physicians and Medical Students with Disabilities D-615.977
Our AMA will: (1) establish an advisory group composed of AMA members who themselves have a disability to ensure additional opportunities for including physicians and medical students with disabilities in all AMA activities; (2) promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent; (3) develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians and medical students to manage their own disability-related needs in the workplace; and (4) communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable accommodations for physicians and medical students with visible and invisible disabilities. [BOT Rep. 19, I-21]

AMA Support of American Indian Health Career Opportunities D-350.976

1. Our American Medical Association will work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Association of American Indian Physicians, and Association of Native American Medical Students to increase representation of American Indian physicians in medicine by promoting effective practices in recruitment, matriculation, retention and graduation of American Indian medical students.
2. Our AMA will Convene key parties, including but not limited to the Association of American Indian Physicians (AAIP) and American Indian/Alaska Native (AI/AN) tribes/entities such as Indian Health Service and National Indian Health Board, to discuss the representation of AI/AN physicians in medicine and promotion of effective practices in recruitment, matriculation, retention, and graduation of medical students. [BOT Action in response to referred for decision: Res. 308, A-22; Modified: BOT Rep. 31, A-24; Reaffirmed: BOT Rep. 31, A-24]

Indian Health Service H-350.977
The policy of the American Medical Association is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. Our AMA specifically recommends:

1. Indian Population:

   a. In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently;
   b. Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care;
   c. Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and
   d. Improvement in transportation to make access to existing private care easier for the American Indian population.
2. Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
3. Personnel:
   a. Compensation scales for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service;
   b. Consideration should be given to increased compensation for specialty and primary care service in remote areas;
   c. In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers and other federal health agencies, thus increasing both the available staffing and the level of professional expertise available for consultation;
   d. Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served without detracting from physician compensation;
   e. Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation and burnout; and
   f. Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
4. Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
5. Our AMA also supports the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.
6. Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.
7. Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.
8. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate, but incremental, loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program.
9. Our AMA supports reform of the Indian Health Service (IHS) Loan Repayment Program eligibility for repayment with either a part-time or full-time employment commitment to IHS and Tribal Health Programs. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Appended: Res. 305, A-23; Reaffirmed: BOT Rep. 09, A-23;

Reaffirmed: CMS Rep. 03, A-24; Reaffirmed: Res. 244, A-24; Reaffirmed: BOT Rep. 31, A-24; Modified: CMS Res. 305, A-24]